# WALKER STANDARD WRITTEN ORDER

**Please fax to:**
**Anchorage (907) 274-0773**
**Fairbanks (907) 458-8914**
**Soldotna (907) 260-3757**
**Wasilla (907) 357-7883**
**or email to:**
**dme@procarehm.com**

**Patient Name, Address, Telephone & Insurance ID#:**

**Phone:** ______________________ **Ins ID#:**_______________

**Patient DOB:**____________________ **Sex:** ______**(M/F)**

Refer to ambulatory aids coverage criteria sheet for all required documentation.

Date of Last Visit: ___________________________________

Diagnosis and Code: ___________________________________________________________________________

Length of Need (# of months)_______________1-99 (99=lifetime) Patient Height: ______ in. Patient Weight: _______ lbs.

**AMBULATORY AIDS:** Select One

**Standard Equipment**

Hemi Walker, 250lb max (E0135)
Walker, without wheels 300lb max (E0135)
Front Wheeled Walker, 300lb max (E0143)
4 Wheeled Walker with Seat, 300lb max (E0143/E0156)

**Bariatric Equipment**

Front Wheeled Walker, Heavy Duty, 500lb max (E0149)
4 Wheeled Walker with Seat, Heavy Duty 500lb max (E0149/E0156)

**Optional Equipment** (Standard Equipment Only)

Walker Platform Attachment Left Side (E0154)
Walker Platform Attachment Right Side (E0154)

PROVIDER CERTIFICATION:

I, the patient's treating provider, certify the medical necessity of these items for this patient and maintain medical records reflecting the medical justification and care provided.

Provider's Signature: _____________________________________________ Date: ___________ NPI: _________________

Provider's Name: _____________________________________________ Telephone: _______________________________