WALKER STANDARD WRITTEN ORDER

PROCARE HOME MEDICAL

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: _____ Patient Height: _____ in. Patient Weight: _____lbs.

Length of Need (# of months)_____1-99 (99=lifetime) Order Date:_____

AMBULATORY AIDS: *Select One*

Standard Equipment

- ☐ Hemi Walker, 250lb max (E0135)
- ☐ Walker, 300lb max (E0135)
- ☐ Front Wheeled Walker, 300lb max (E0143)
- ☐ 4 Wheeled Walker with Seat, 300lb max (E0143/E0156)
- ☐ Knee Walker 300lb max (E0118)

Bariatric Equipment

- ☐ Front Wheeled Walker, HD, 500lb max (E0149)
- ☐ 4 Wheeled Walker with Seat, HD 500lb max (E0149/E0156)

Optional Equipment (Standard Equipment Only)

- ☐ Walker Platform Attachment (E0154)
- ☐ 5" Wheels, Walker, Attachment (E0155)
- ☐ Tall Leg Extensions, Walker (E0158)
- ☐ Tall Wheel Extensions, Walker (E0158)

MEDICAL NECESSITY INFORMATION: *Must also be supported in the medical records, if applicable*

1. Does the patient have a mobility limitation that significantly impairs his/her ability to participate in one or more mobility related activities of daily living (MRADL) in the home? ☐ Y ☐ N

Reason for mobility limitation:

A. Prevents the patient from accomplishing the MRADL entirely, ☐ Y ☐ N
or
B. Places the patient at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform the MRADL, ☐ Y ☐ N
or
C. Prevents the patient from completing the MRADL within a reasonable time frame. ☐ Y ☐ N

2. Is the patient able to safely use the walker? ☐ Y ☐ N
3. Is the functional mobility deficit sufficiently resolved with the use of a walker? ☐ Y ☐ N

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: _____