Patient Information

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_Zip\_\_\_\_\_\_

Primary Insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Discharge Date\_\_\_\_\_\_\_\_\_\_\_\_ Height\_\_\_\_\_\_\_Weight\_\_\_\_\_\_Diagnonsis Codes\_\_\_\_\_\_\_\_\_\_\_\_\_Length of Need(# of Months)\_\_\_\_\_\_\_\_1-99 (99=Lifetime)

**WALKER STANDARD WRITTEN ORDER**

| **Standard Equipment**   * Hemi Walker, 250lb max * Front Wheeled Walker, 300lb max * 4 Wheeled Walker with Seat, 300lb max | **Bariatric Equipment**   * Front Wheeled Walker, HD, 500lb max * 4 Wheeled Walker with Seat, HD 500 lb max | **Accessories**   * Walker Platform Attachment * Tall Leg Extensions |
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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? \_\_\_\_YES\_\_\_NO  
     
   Reason for Mobility Limitation:
   1. Prevents the patient from accomplishing the MRADL entirely\_\_\_\_YES\_\_\_NO  
      **OR**
   2. Places the patient at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform the MRADL\_\_\_\_YES\_\_\_NO  
      **OR**
   3. Prevents the patient from completing the MRADL within a reasonable time frame\_\_\_\_YES\_\_\_NO
2. Is the patient able to safely use the walker?\_\_\_\_YES\_\_\_NO
3. Is the functional mobility deficit sufficiently resolved with the use of a walker?\_\_\_\_YES\_\_\_NO

| 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 Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_NPI:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Provider Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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