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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