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: _____ Order Date: _____

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: _____