TODAYS DME INC

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Detailed Written Order Prior to Delivery

Patient Name: _____ Patient DOB: _____

Order Date: _____

☑ **Chart notes Attached** (chart notes must include the need for equipment being ordered) F2F Referral Chart notes for sleep study and Diagnostic Sleep Study

I, the undersigned, certify that the below prescribed equipment/supplies is medically necessary as part of my treatment plan for this patient. In my opinion, the equipment prescribed is reasonable and necessary for accepted standards of medical practice and treatment of this patient's condition and has not been prescribed as "convenience equipment". I have documented the following information and the need for this equipment in the patient's most recent chart notes.

DIAGNOSIS (Check appropriate diagnosis below) Length of Need: ☐ 12 months ☑ 99 months

ICD-10 Diagnosis Code(s):

R26.2 difficulty in walking, not elsewhere classified Other _____

R29.6 Recurrent Falls R26.81 Unsteady Gait

Rollator Products & accessories are medically necessary (Check equipment/supplies ordered)

QTY	HCPC Code	Description of specific services to be provided
	E0141	2 wheeled rigid walker, adjustable or fixed height
1	E0143	2 wheeled folding walker, adjustable or fixed height under 300 lbs
	E0147	2 wheeled heavy duty walker, rigid/folding
	E0148	Heavy Duty Walker, without wheels
	E0149	2 wheeled walker heavy duty, folding
1	E0156	Walker Seat attachment

Accessories / Options not covered by insurance

☑ Basket ☑ 4 wheels ☑ hand brakes

Additional Information:

1) Does the patient have a mobility limitation that significantly impairs ability to participate in one or more mobility-related activities of daily living (MRADL) in the home. A mobility limitation is one that:	☐ YES	☐ NO
1a) Prevents the patient from accomplishing the MRADL Entirely **OR**	☐ YES	☐ NO
1b) Places patient at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform the MRADL **OR**	☐ YES	☐ NO
1c) Prevents the patient from completing the MRADL within a reasonable time frame **AND**	☐ YES	☐ NO
2) The Patient is able to safely use the walker **AND**	☐ YES	☐ NO
3) The functional mobility deficit can be sufficiently resolved with use of a walker	☐ YES	☐ NO

4) Does the patient have a medical condition that impairs ambulation?	☐ YES	☐ NO
5) Is there a potential for ambulation?	☐ YES	☐ NO
6) Does the patient require greater stability than a cane or crutches can provide?	☐ YES	☐ NO
7) What does the patient weight _____ lbs		
8) Does the patient's height exceed 6ft?	☐ YES	☐ NO
9) Does the patient have a severe neurologic disorder or the other condition causing the restricted use of one hand?	☐ YES	☐ NO

Prescribing Physician's Information

Name & Credentials _____ NPI# _____

Telephone _____ Fax _____

Address _____

Signature _____ Signature Date _____