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# Physician's Order Form for Walker with Seat (E0143 & E0156)

**Date Ordered:** ___/___/_____ ☐ Initial ☐ Renewal **Date of Face to Face:** ___/___/_____

**Patient's Name:** _____ **DOB:** _____/_____/_____

**Patient's Address:** _____

_____

**Insurance ID #:** _____ **Height:** ____'____" **Weight:** _____**lbs**

**The physician must complete this information in order to comply with Medicare Guidelines**

**Diagnosis/ICD-10 Code:**_____ **Length of Need:** _____

****Please answer <u>all</u> of the following questions****

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) such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home? ☐ Yes ☐ No
2. Can the mobility deficit be sufficiently resolved by the use of an appropriately fitted cane or crutch? ☐ Yes ☐ No
3. Will the functional mobility deficit be sufficiently resolved with the use of a walker? ☐ Yes ☐ No
4. Is the patient able to safely use the walker? ☐ Yes ☐ No
5. Does the patient have upper body weakness which prevents him/her from picking up a standard walker? ☐ Yes ☐ No
6. Does the patient have limited use of one hand, neurological disorders or severe obesity? ☐ Yes ☐ No
7. Is this walker being ordered with a seat? ☐ Yes ☐ No

**Physician Name:**_____ **NPI #** _____

**Physician's Address:**_____

I, the undersigned, certify the above prescribed equipment and/or supplies are medically necessary as part of my treatment for this patient. In my opinion, the equipment and/or supplies prescribed are both reasonable and necessary for accepted standards of medical practice and treatment of this patient's condition. Neither the equipment and/or supplies are being prescribed as "convenience equipment".

**Physician's Signature :**_____**Date** ____/____/_____

LC