Stoll's Pharmacy, Inc.
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Cane, Crutches, and Walker

Patient Name: _____ Date of Birth ____/____/____

Patient Street Address: _____ City, ST, Zip: _____

Dear Prescriber,

Stoll's Pharmacy, Inc. is in receipt of an order placed by you or your staff to provide services for your patient listed above. The information below is a written confirmation of this order. **Please fill in all pertinent information as well as modify any incorrect entries so that your patient receives their full medical insurance benefit.**

Equipment Ordered; Order start date: _____/_____/_____

_____ E0100 Cane
_____ E0105 Quad Cane
_____ E0112 Crutches, Underarm, Wood, Pair, With Pads, Tips, Handgrips
_____ E0114 Crutches, Underarm, Aluminum, Pair, With Pads, Tips, Handgrips
_____ E0130 Walker, Rigid (Pickup)
_____ E0135 Walker, Folding (Pickup) _____ E0148 Walker, Heavy Duty, Without Wheels*
_____ E0143 Walker, Folding, Wheeled_____ E0149 Walker, Heavy Duty, Wheeled*
_____ E0156 Seat Attachment, Walker *Patient Weight: _____ (Required For E0148 E0149)
_____ Other (Please Describe In Detail):

[ ] Yes [ ] No Does the patient have a mobility limitation that significantly impairs his or her ability to participate in one or more mobility-related activity of daily living (MRADL) in the home.

This mobility limitation is one that (please select any or all of the following):
_____ Prevents the patient from accomplishing the MRADL entirely.

_____ Places the patient at reasonably determined heightened risk of morbidity or mortality secondary to attempts to perform the MRADL

_____ Prevents the patient from completing the MRADL within a reasonable time frame

[ ] Yes [ ] No Is the patient able to safely use this equipment?
[ ] Yes [ ] No Is the functional mobility deficit sufficiently resolved by use of this equipment?

Pertinent diagnosis (**ICD-10-CM Code**);

Length of need: [ ] _____ Months [ ] Lifetime

Please complete and sign below to indicate your acceptance of the above information and return the original form to us in the envelope provided. If you have any questions, please contact us at (203) 575-0199

Doctor Name: _____ **Prescriber NPI #:** _____

Street Address: _____**City, ST, Zip** _____

Signature: _____ **Date Signed:** ____/____/___

SIGNATURE AND DATE STAMPS ARE NOT ACCEPTED BY INSURANCE COMPANIES

Signing Prescribers NPI # (If Different from above) _____