DR.

Ph: _____ ADDRESS:
Fax: _____
NPI: _____

Patient Name: _____ **Weight:** _____ **Height:**

DOB:_____ **AGE:** _____

Address:

RX Mobility Equipment (Only use if patient's weight is less than 300 lbs)

☐ E0114 - **Crutches**- Underarm

☐ E0110- **Crutches-** Forearm

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☐ E0135 – **Folding Walker**
☐ **Platform attachment**

☐ E0143- **Folding Walker with Two Front Wheels**
☐ **Platform Attachment**

☐ E0143- **Walker Rollator**
E0156 – **With seat, brakes, and Basket**

☐ E0100 – **Standard Straight Cane**

☐ E0105 **Quad Cane (Four Prong Cane)**

DX:_____

_____

_____

ICD – 9 _____

I, undersigned, certify that the above prescribed equipment is medically necessary for this patient to achieve one or more MRADL's in the home. In my opinion, this equipment and accessories are both reasonable and necessary to accepted standards of medical practice in treatment of this patient's condition and are not prescribed as convenience supplies. By signing this form, I am confirming that the above information is accurate.

Physician signature _____ Date _____