847-824-0500 * PULMONARY PROVIDERS GROUP, INC. * 847-824-0529 fax

CERTIFICATE OF MEDICAL NECESSITY

Canes or Crutches Order Form

Referral Source:_____ Referral Source Phone:_____

PATIENT INFORMATION

Last Name:_____ First Name:_____

Address: _____

City:_____ State: Illinois Zip code:_____

Phone Number: (_____)_____

Sex: Female_____ Male_____ Birth Date:_____/_____/_____

Height:_____ Weight:_____

DIAGNOSIS INFORMATION

Primary :_____

Secondary:_____

INSURANCE INFORMATION

Medicare Number:_____

Medicaid Recipient Number:_____

Private Insurance Number:_____ Group Number:_____

PRODUCT(S) REQUESTED

*Cane [ ] Straight; [ ] Ortho	*Quad Cane [ ]Small Base [ ]Large Base	[ ]*Crutches

*are covered if all of the following criteria (1-3) are met:

The patient's medical records must contain the following information:

1. The beneficiary has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADL) in the home.

The MRADLs to be considered in this and all other statements in this policy are toileting, feeding, dressing, grooming, and bathing performed in customary locations in the home.

A mobility limitation is one that:

a. Prevents the beneficiary from accomplishing the MRADL entirely, or,

b. Places the beneficiary at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL; or,

c. Prevents the beneficiary from completing the MRADL within a reasonable time frame;

And

2. The beneficiary is able to safely use the cane or crutch; and,

3. The functional mobility deficit can be sufficiently resolved by use of a cane or crutch.

If all of the criteria are not met, the cane or crutch will be denied as not reasonable and necessary

Length of Need:_____(1-99 Months) 99=Lifetime

PHYICIAN INFORMATION

Name:_____

Address:_____

City:_____ State:_____ Zip code:_____

Phone Number:(_____)_____

NPI:_____

I, the undersigned, certify that the above prescribed Durable Medical Equipment/Supplies are medically necessary as a part of my treatment for this patient. In my opinion, the equipment/item(s) prescribed are reasonable and necessary for the accepted standards of medical practice and treatment in patient's condition.

Physician Signature:_____ Date:_____/_____/_____