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

CERTIFICATE OF MEDICAL NECESSITY

Walker 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

[ ] *Walker Standard [ ] without wheels [ ] with wheels

[ ] *Walker Heavy duty > 300lbs; [ ] without wheels; [ ] with wheels

* 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.
   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 the 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 walker; and
3. The functional mobility deficit can be sufficiently resolved with use of a walker.

If all of the criteria are not met, the walker 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:_____/_____/_____