WOUND CARE SOLUTIONS, INC.

Office Hours: M-F: 8:00am-5:00pm Sat: 9:00am-3:00pm
Delivery Times Start at 8:00am
Call: (312)-738-2330
FAX:(312)738-2395

Walker Order Form

Check and sign below to order a walker.
Fax supporting medical notes demonstrating medical necessity

according to Medicare guidelines.

Medical Notes Must Contain:

1) The patient 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.
2) The patient is able to safely use the walker; and
3) The functional mobility deficit can be sufficiently resolved with use of a walker.

Patient Name: _____ Height: _____ Weight: _____ Date Last Seen: ___ / ___ / ___

Estimated Length of Need (99 = Lifetime): _____ Diagnosis: _____

ICD 10 Codes: _____ Patient DOB: ____ / _____ / _____

SSN: _____ Start Date: _____

Please check the box to indicate you're ordering a walker for your patient.

☐ **STANDARD WALKER (E0143)**

☐ **JUNIOR WALKER (E0143[2])**

I certify that this patient is under my care and that that the above prescribed equipment/supplies are medically necessary as part of my treatment for this patient and has not been prescribed as "convenience equipment."

Physician Name: _____Physician Signature: _____

NPI: _____ Date: ___ / ___ / ___ Time: _____

Address: _____

Phone: _____ Fax: _____

REVISION: 10/14/2016