APRIA®

Walkers, Canes, Crutches Order Form

Fax completed form to: _____

Apria Representative _____ **Branch Location** _____ **Phone** _____

REFERRAL SOURCE

Referral name _____ Referral contact name _____

Order date _____ Phone _____ Fax _____

PATIENT INFORMATION

Patient name _____ DOB _____
Last First

Home phone _____ Mobile phone _____ Email _____

Delivery address: Street _____ City _____ State _____ Zip _____

Estimated length of need: _____ months (99 = lifetime) Height _____ Weight _____

Diagnosis ICD-10: Each diagnosis requires a corresponding ICD-10 code and must be corroborated in the patient's medical record. Please enter the appropriate qualifying diagnoses and corresponding ICD-10 codes (Note: ranges are not acceptable). _____

PLEASE PROVIDE MEDICAL RECORDS THAT SUPPORT COVERAGE FOR THE EQUIPMENT ORDERED.
PLEASE PROVIDE PATIENT DEMOGRAPHICS AND INSURANCE INFORMATION.

All qualifying criteria MUST BE DOCUMENTED in the patient's medical record.

Walkers, canes and crutches are covered items if:

- The patient has a mobility limitation that significantly impairs his/her ability to participate in one or more Mobility Related Activities of Daily Living (MRADLs) in the home. MRADLs are toileting, feeding, dressing, grooming, and bathing performed in customary locations in the home. A mobility limitation is one that:
  - Prevents the patient from accomplishing the MRADLs entirely, ***or***
  - Places the patient at a reasonably determined heightened risk of illness, injury, or death secondary to the attempts to participate in MRADLs, ***or***
  - Prevents the patient from completing the MRADLs within a reasonable time frame

For a walker, the following criteria also must be met:

- The patient must be able to safely use the walker, ***and*** the functional mobility deficit must be sufficiently resolved by use of a walker.

For a heavy-duty walker, the following criteria also must be met:

- The patient must meet requirements for a walker, ***and*** **weigh** more than 300 lbs.

For walker leg extensions, the following criteria also must be met:

- Patient meets requirements for a walker, ***and*** is at least 6 feet tall.

For a cane or crutches, the following criteria also must be met:

- Patient must be able to safely use the cane or crutch, ***and*** the functional mobility deficit can be sufficiently resolved by use of a cane or crutch.

EQUIPMENT ORDERED

- ☐ Folding walker pickup, adj/fxd height (E0135)
- ☐ Folding walker, wheeled, adj/fxd height (E0143)
- ☐ Heavy-duty walker, without wheels (E0148)
- ☐ Heavy-duty walker, wheeled (E0149)
- ☐ 4-wheeled walker with seat and brakes (E0143, E0156)
- ☐ Leg extensions for walker, per set of four (E0158)
- ☐ Wheel attachment, rigid pickup walker, per pair (E0155)
- ☐ Forearm attachment for walker (E0154)
- ☐ Crutches, forearm, adj/fxd, pair, with tips and handgrips (E0110)
- ☐ Crutches underarm, other than wood, adj/fxd, pair, with pads, tips and handgrips (E0114)
- ☐ Crutch substitute, lower leg platform (E0118)
- ☐ Cane, adj/fxd, with tips (E0100)
- ☐ Cane, quad or three prong, adj/fxd, with tips (E0105)
- ☐ Other _____
- ☐ Other _____

By my signature below, I authorize the use of this document as a dispensing prescription. I understand that the final decision with respect to ordering this (these) item(s) for this patient is a clinical decision made by me, based on the patient's clinical needs, and that my records concerning this patient support the medical need for the items prescribed.

Print prescriber's name _____ **Prescriber email** _____ **NPI #** _____

Prescriber's signature _____ **Date** _____

©2020 Apria Healthcare Group Inc.