NORTHEAST MEDICAL PRODUCTS, INC
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WALKER ORDER FORM

Patient Name ____ DOB __________________

Address ____Length of Need___________

Diagnosis codes ___________________________ Height__________Weight______________

Equipment ordered:

_____ E0135 Walker, folding (pickup), adjustable or fixed height
_____ E0135 Walker, hemi, adjustable
_____ E0143 Walker, folding, wheeled, adjustable or fixed height
_____ E0156 Seat attachment, walker
_____ A9270 Non covered item or service (brakes, basket)
_____ E0148 Walker, heavy duty (over 350 lbs), no wheels, rigid or folding, any type
_____ E0149 Walker, heavy duty (over 350 lbs), wheeled, rigid or folding, any type
_____ E0154 Platform attachment, walker, each ________Left _______Right

Coverage Questions:

Y N Does the patient have a mobility limitation that significantly impairs his/her ability to participate in one or more mobility related activities of daily living in the home?

Y N Is the patient able to safely use the walker?

Y N Can the patient's functional mobility deficit be sufficiently resolved with the use of a walker?

Physician Name____

Address ____

Phone ___________________________ Fax ________________________

NPI ______________________________________

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Physician Signature Date