StabilizedSteps
Home of the STABILIFE SYSTEM

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Detailed Written Order Prior to Delivery

Patient Name: _____ Order Date: _____

Account #: _____ Patient DOB: _____

Height: _____ Weight: _____

☐ ***Face Sheet/Demographics attached***

☐ ***Chart Notes Attached*** *(Chart notes must include the need for the equipment being ordered)*

☐ I, the Physician, have treated this patient for a condition that supports the need and have discussed the need for this medical equipment with the patient and caregivers. I have documented the following information and the need for this equipment in the patient's most recent chart notes. **Date of visit prior to order:** _____

DIAGNOSIS *(Check appropriate diagnosis below)*

Length of Need in Months _____ (99 = Lifetime)

☐ Osteoarthritis of hip (M16)	☐	☐ Other: _____
☐ Osteoarthritis of Knee (M17)	☐	☐ Other: _____
☐ Other and unspecified osteoarthritis (M19)	☐	☐ Other: _____

EQUIPMENT *(Check equipment below)*

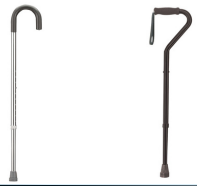
☐ Folding Walker
☐ Walker Platform Attachment, Right Side
☐ Walker Platform Attachment, Left Side

☐ Folding Walker - Junior
☐ Folding Walker - Bariatric (301lbs.+)

☐ Folding Walker with Wheels
☐ Folding Walker with Wheels (Junior)

☐ Small Base Quad Case
☐ Large Base Quad Cane

☐ Straight Cane
☐ Heavy Duty Cane (301lbs.+)



☐ Wheel Attachment

NECESSITY FOR MOBILITY ASSISTIVE EQUIPMENT *(MAE) (Check all that apply)*

Does the patient have a mobility limitation that impairs participation in Mobility Required Activities of Daily Living in the home?

☐ **Yes**. If yes, go to the next question ☐ **No**. ***If No, Stop!*** Patient does not qualify.

Can patient limitation be compensated for by the addition of the equipment to improve the ability to participate in Mobility Required Activities of Daily Living in the home?

☐ **Yes**. If yes, go to the next question ☐ **No**. ***If No, Stop!*** Patient does not qualify.

Is the patient capable and willing to operate the equipment safely in the home?

☐ **Yes**. If yes, go to the next question ☐ **No**. ***If No, Stop!*** Patient does not qualify.

Can the mobility deficit be safely resolved by the equipment described above?

☐ **Yes**. If yes, go to the next question ☐ **No**. ***If No, Stop!*** Patient does not qualify.

Prescribing Physician's Information

Name & Credentials: _____ **NPI #:** _____

Telephone: _____ **Fax:** _____

Address: _____

Prescriber Signature: _____ **Signature Date:** _____

If filled out completely, this form serves as proof that patient was seen by the physician within 6 months prior to the date of order.

Canes, crutches, standard walkers and related accessories are covered if all of the following criteria 1 through 3 are met:

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: Prevents the beneficiary from accomplishing the MRADL entirely, or Places the beneficiary at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform the MRADL, or Prevents the beneficiary from completing the MRADL within a reasonable time frame and
2. The beneficiary is able to safely use the equipment; and
3. The functional mobility deficit can be sufficiently resolved with use of the equipment. If all of the criteria are not met, the equipment will be denied as not reasonable and necessary.

A heavy duty walker (E0148, E0149) is covered for beneficiaries who meet coverage criteria for a standard walker and who weigh more than 300 pounds. If an (E0148 or E0149) walker is provided and if the beneficiary weighs 300 pounds or less, it will be denied as not reasonable and necessary.

A heavy duty, multiple braking system, variable wheel resistance walker (E0147) is covered for beneficiaries who meet coverage criteria for a standard walker and who are unable to use a standard walker due to a severe neurologic disorder or other condition causing the restricted use of one hand. Obesity, by itself, is not a sufficient reason for an E0147 walker. If an E0147 walker is provided and if the additional coverage criteria are not met, it will be denied as not reasonable and necessary.

Medicare requires that it is a physician (MD, DO, or DPM), physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS) perform the office visit examination with the beneficiary.