



**NORTHEAST MEDICAL PRODUCTS, INC**  
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**WALKER ORDER FORM**

Patient Name \_\_\_\_\_ TEL \_\_\_\_\_

Address \_\_\_\_\_

Diagnosis Codes: \_\_\_\_\_ Length of Need \_\_\_\_\_

DOB: \_\_\_\_\_ 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 300 LBS), no wheels, rigid or folding, any type
- \_\_\_\_\_ E0149 Walker, heavy duty (over 300 LBS), wheeled, rigid or folding, any type
- \_\_\_\_\_ E0154 Platform attachment, walker, each \_\_\_\_\_ Left \_\_\_\_\_ Right
- \_\_\_\_\_ E0147 Walker, neurological

**Note:** For 4-wheel walkers with seat (Rollator), please check E0143, E0156, and A9270

**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 \_\_\_\_\_

Physician Signature \_\_\_\_\_

Date \_\_\_\_\_