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An Innova Medical Group Company



INNOVA MEDICAL PRODUCTS

U-STEP WALKER PRESCRIPTION FORM

Patient Name _____ Phone _____

Address _____

Email _____

DOB _____ Length of Need _____

Diagnosis & ICD10 Code(s) _____

Alternate Contact Name _____ Relationship _____ Phone _____

Please answer the following questions to determine medical necessity for insurance coverage

Yes/No Does the patient have a severe walking problem that places him/her at heightened risk of morbidity or mortality without a walking-aid?

Yes/No Will a cane or crutch be sufficient in preventing your patient from falling and injuring himself/herself?

Yes/No Will a standard walker be sufficient for preventing your patient from falling and injuring himself/herself?

Yes/No Are you prescribing the U-Step 2 Walking Stabilizer because your patient has a severe neurological condition or limited use of a hand, and requires this product to safely ambulate and prevent serious injury due to risk of falling?

Yes/No Will your patient's mobility deficit be sufficiently resolved by using a U-Step 2?

What products are you prescribing for your patient?

☐ E0147 – U-Step Walking Stabilizer (DMERC MODEL #US-PC-2)

☐ E0156 – Accessory Seat for walker

☐ E0154 – Platform Attachments for walker

☐ Cueing Module (Laser and Auditory Cue for Parkinson's freezing)

Physician Printed Name _____ NPI _____

Phone _____ Fax _____

Physician Address _____ City, State _____

By signing below, I authorize the use of this document as a legal prescription, and I certify that the above prescribed equipment is medically necessary, reasonable, accurate and complete and is not being prescribed for convenience. I will maintain an original signed copy of this order in my medical records and make it available to Medicare, their authorized agents or other insurer, if required.

Physician Signature _____ Date _____