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INNOVA MEDICAL PRODUCTS

WALKER PRESCRIPTION FORM

Patient Name _____ Phone _____

Address _____

Email _____

Diagnosis Codes _____ Length of Need _____

DOB _____ Height _____ Weight _____

Alternate Contact: Name _____ Relationship _____ Phone _____

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

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 _____ NPI _____

Address _____

Phone _____ Fax _____

Physician Signature _____ Date _____