DWO for U Step Walker

FAX COMPLETED DWO, PATIENT DEMOGRAPHICS AND SUPPORTING MEDICAL NOTES TO 207-221-9622

DATE OF ORDER:_____

DATE OF LAST FACE TO FACE:_____

PATIENT INFORMATION

First Name_____ **Last Name**_____

Address_____ **City**_____ **State**_____ **Zip**_____ **Phone**_____

Date of Birth_____ **Emergency Contact**_____ **Emergency Contact Phone**_____

REFERRING PT OR CLINIC INFORMATION (if applicable)

Clinic Name_____ **Therapist Name** _____

Clinic Address_____ **City**_____ **State**_____ **Zip**_____

Phone_____ **Fax**_____**Therapist Email**_____

PRODUCT PRESCRIBED

☐ U Step standard walker E0147 with seat attachment E0156

☐ U Step platform walker E0147 with seat attachment E0156 and Platform attachment E0154

☐ U Step press down walker E0147 with seat attachment E0156

ANSWER ALL QUESTIONS BELOW

☐ Yes ☐ No 1. Does the patient have a neurological condition?

☐ Yes ☐ No 2. Does the patient live in a skilled nursing facility?

☐ Yes ☐ No 3. Has the patient had a mobility item paid for by Medicare in the last 5 years?

DIAGNOSIS

Primary ICD10 Numeric Code:_____ **Secondary ICD10 Numeric Code:**_____

PHYSICIAN INFORMATION (Must be MD, DO, NP or PA)

By signing and dating, I attest to prescribing the above mentioned item(s). In my professional opinion, the item(s) is both reasonable and necessary in reference to the current accepted standards of medical practice and treatment of this patient's condition. All other related treatments have been tried or considered and ruled out.

Physician Name_____ **NPI#**_____ **Phone**_____ **Fax**_____

Physician Address_____ **City**_____ **State**_____ **Zip**_____

Physician Signature_____ **Date Signed**_____

DO NOT SUBSTITUTE