



Cane & Crutches Standard Written Order

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Patient Name: _____ Phone #: _____

Address: _____

Ins ID#: _____ Patient DOB: _____ Sex: ☐ Male ☐ Female

Refer to Cane & Crutches coverage criteria sheet for all required documentation.

AMBULATORY AIDS:

Date of Last Visit: _____

Diagnosis and Code: _____

Length of Need (# of months) _____ 1-99 (99=lifetime) Patient Height: _____ in. Weight: _____ lbs.

Standard Equipment

- ☐ Cane, 700 lb. max (E0100)
- ☐ Quad Cane, 500 lb. max (E0105)
- ☐ Forearm Crutches, 500 lb. max (E0110)
- ☐ Underarm (Auxiliary) Crutches, 650 lb. max (E0114)

Provider Certification:

I, the patient's treating provider, certify the medical necessity of these items for this patient and maintain medical records reflecting the medical justification and care provided.

Provider's Signature: _____ Date: _____ NPI: _____

Providers Name: _____ Telephone: _____