



Walker Standard Written Order

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Patient Name: _____ Phone #: _____

Address: _____

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

Refer to ambulatory aids coverage criteria sheet for all required documentation.

AMBULATORY AIDS: Select One

Date of Last Visit: _____

Diagnosis and Code: _____

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

Standard Equipment

- ☐ Hemi Walker, 250 lb. max (E0135)
- ☐ Walker, without wheels, 300 lb. max (E0135)
- ☐ Front Wheeled Walker, 300 lb. max (E0143)
- ☐ 4 Wheeled Walker with Seat, 300 lb. max (E0143/E0156)

Bariatric Equipment

- ☐ Front Wheeled Walker, Heavy Duty, 500 lb. max (E0149)
- ☐ 4 Wheeled Walker with Seat, Heavy Duty, 500 lb. max (E0149/E0156)

Optional Equipment (Standard Equipment Only)

- ☐ Walker Platform Attachment Left Side (E0154)
- ☐ Walker Platform Attachment Right Side (E0154)

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: _____