Walker Standard Written Order

Fax: 602-428-6841
Phone: 480-795-7955
Orders@MyTritonSupply.com

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: _____