BECN 15279009557

BINSON'S Medical Equipment & Supplies Since 1953

1-888-BINSONS
Fax: 586-755-2322

Reset Form

Canes/Walkers - Detailed Written Order Prior to Delivery

Patient Name _____ Account Number _____

Patient DOB _____ Order Date _____ Height _____ Weight _____

☐ Face Sheet/Demographics/Chart Notes Attached **(Chart notes must include the need for equipment being ordered).**

☒ I, the Physician, have treated this patient for a condition that supports the need and have discussed the need for this medical equipment with the patient and caregivers. I have documented the following information and the need for this equipment in the patient's most recent chart notes. **Date of visit prior to order**: _____

***MUST BE FILLED OUT FOR MEDICAID PATIENTS ONLY:**
Reason for Medical Necessity (other than diagnosis): _____

DIAGNOSIS (check applicable diagnosis below) **Length of Need:** ☐ 12 Months ☐ Other _____ 99 = Lifetime

☐ Alzheimer's	☐ CHF	☐ CVA	☐ Osteoarthritis
☐ Osteoporosis	☐ Parkinson's	☐ Rheumatoid Arthritis	☐ Other: _____

EQUIPMENT (check equipment below)

☐	**Folding Walker** 	☐	**Folding Walker w/ Wheels** 	☐	**Hemi Walker** 	☐	**Heavy Duty Walker (301 lbs +)** 
☐	**Wheel Attachment (pair)** 	☐	**Walker w/ Wheels, Seat, Brake** 	☐	**Heavy Duty Walker w/ Wheels, Seat, Brake (301+ lbs)** 	☐	**Small Base Quad Cane** 
☐	**Large Base Quad Cane** 	☐	**Straight Cane**	☐	**Heavy Duty Cane (301 lbs +)** 	☐	**Standard Crutches** 
☐	**Forearm Crutches** 	☐	**Platform Attachment** 				

NECESSITY FOR MOBILITY ASSITIVE EQUIPMENT (MAE) (Check all that apply)

Does the patient have mobility limitation that impairs participation in Mobility Require Activities of Daily Living in the home?
☐ **YES**. If yes, go to the next question. ☐ **NO**. If no, stop; patient does not qualify.

Can patient limitation be compensated for by the addition of the equipment to improve the ability to participate in Mobility Required Activities of Daily Living in the home?
☐ **YES**. If yes, go to the next question. ☐ **NO**. If no, stop; patient does not qualify.

Is the patient capable and willing to operate the equipment safely in the home?
☐ **YES**. If yes, go to the next question. ☐ **NO**. If no, stop; patient does not qualify.

Can the mobility deficit be safely resolved by the equipment described above?
☐ **YES**. If yes, complete the order. ☐ **NO**. If no, stop; patient does not qualify.

PRESCRIBING PHYSICIAN'S INFORMATION

Name and Credentials _____ NPI No. _____

Telephone No. _____ Fax No. _____

Signature _____ Signature Date _____
(Stamped Signature Not Accepted)

If filled out completely, this form serves as the Detailed Written Order (DWO) and proof that patient was seen by the physician within 6 months prior to the date of order.

This must be received by the supplier before equipment is dispensed.

A small volume nebulizer, related compressor and FDA approved inhalation solutions are covered when:

- It is reasonable and necessary to administer the drugs to a beneficiary:
  - For the management of obstructive pulmonary disease,
  - With cystic fibrosis,
  - With bronchiectasis,
  - With HIV, pneumocystis, or complications of organ transplants,

    or

  - For persistent thick or tenacious pulmonary secretions.

If none of the drugs used with a nebulizer are covered, the compressor, the nebulizer, and other related accessories/supplies will be denied as not reasonable and necessary.

Medicare requires that it is a physician (MD, DO, or DPM), physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS) perform the office visit examination with the beneficiary.

The chart note from the office visit exam must be signed and dated by the author of the note. If completed by a PA, NP, or CNS, the physician (MD, DO or DPM) must cosign and date the note.