



**MRADLS**

(Mobility Related Activities to Daily Living)  
Written Order Prior to Delivery (WOPD)

**Fort Medical Equipment LLC**  
306 Washington Street  
Fort Atkinson, WI. 53538-1741  
Phone: 920-568-9860  
Fax: 872-469-1691

Order Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Diagnosis:  1 \_\_\_\_\_  2 \_\_\_\_\_  3 \_\_\_\_\_

Duration:  Lifetime (99) Other \_\_\_\_\_ months

**Mobility Device** (select one and indicate size or type if applicable)

Cane (E0100)	<input type="checkbox"/>		
Quad Cane (E0105)	<input type="checkbox"/>		
Crutches (Select Type)	<input type="checkbox"/>	Forearm Pair (E0110)	<input type="checkbox"/>
		Underarm Pair (E0114)	<input type="checkbox"/>
Knee Walker (E0118)	<input type="checkbox"/>	Not covered by Medicare. Circle non-weight bearing lower extremity. Left Right	
Walker-Pick up (w/o wheels)	<input type="checkbox"/>	300 lbs. or under (E0135)	<input type="checkbox"/>
		Over 300 lbs. (E0148)	<input type="checkbox"/>
Walker-with 5" Wheels	<input type="checkbox"/>	300 lbs. or under (E0143)	<input type="checkbox"/>
		Over 300 lbs. (E0149)	<input type="checkbox"/>
Walker Leg Extension (E0158)	<input type="checkbox"/>	Must be over 6 Feet Tall for this item to be covered.	
Rollator	<input type="checkbox"/>	Four Wheeled Walker with Seat 300 lbs. or under (E0143 & E0156)	
Rollator	<input type="checkbox"/>	Four Wheeled Walker with Seat over 300 lbs. (E0149 & E0156)	

PLEASE SUBMIT THIS FORM ALONG WITH A FACE TO FACE, AND CLINICAL NOTES, i.e. doctors, progress, nurses, occupational therapy, and physical therapy notes. The notes must include diagnosis and the need for the equipment. Also, it is required that the date of this form is the same or after the date on the Clinical Notes and Face to Face.

If ordering a walker for toileting or transferring only, but a wheelchair is needed to complete activities of daily living in the home, progress notes must indicate the need for the walker and wheelchair.

The following criteria must be met for the above selected item to be covered.

- \* The beneficiary has a mobility limitation that significantly impairs his/her ability to participate in one or more MRADL in the home.
  - A mobility limitation is one that:
    1. Prevents the beneficiary from accomplishing the MRADL entirely, or
    2. Places the beneficiary at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform the MRADL, or
    3. Prevents the beneficiary from completing the MRADL within a reasonable time frame
 AND
  - \* The beneficiary is able to safely use the walker/cane/crutches; and
  - \* If Cane or Crutches are ordered - The functional mobility deficit can be sufficiently resolved with use of the cane/crutches.
  - \* If a Walker is ordered - The functional mobility deficit can be sufficiently resolved with use of a walker and cane or crutches have been tried and ruled out.

If the criteria are not met, or proper documentation is not received the walker/cane/crutches will be denied as not medically necessary.

Physician Name: \_\_\_\_\_

NPI: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Physician Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

I certify that I am the treating physician identified on this form. Any statement on my letterhead attached here to, has been reviewed and signed by me. I certify that the medical necessity information on this form is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.