



ROLLATOR/WALKER ORDER FORM

Fax Completed Form and Medical Records To: 207-622-0952

Questions call Michelle: 207-621-0698 ext 214

PATIENT INFORMATION:

Form with fields for Patient Information: First Name, Last Name, Date of Birth, Physical Address, City, State, Zip, Phone #, Email, Mobile.

INSURANCE INFORMATION:

Form with fields for Insurance Information: Primary Insurance Name, ID#, Secondary Insurance Name, ID#.

CLINICAL INFORMATION:

Form with fields for Clinical Information: Start Date, Length of need = 99 if lifetime unless otherwise indicated: _____, Primary Diagnosis.

RECOMMENDED EQUIPMENT: (make selection)

Table with 3 columns: Equipment Description, ID#.

A standard walker and related accessories are covered if all of the following criteria(1-3) are met:

Table with 3 columns: Yes/No, Criteria 1, 2, 3.

Additionally:

Table with 3 columns: Yes/No, Question, Answer field.

Medical records that reflect the need for the care provided are required and must be within 6 months of the signed orders

Licensed Healthcare Provider Acknowledges: My signature denotes that the statements above are true, accurate and complete, to the best of my knowledge. I certify that the patient is being treated by me and I have seen the patient in the last 6 months. The patient is informed that s/he will be contacted by Community Pharmacy regarding coverage for items ordered. I authorize the prescription of the supplies above.

Signature of Physician, Nurse Practitioner, Physician Assistant / Printed Name of Physician, Nurse Practitioner, Physician Assistant

NPI: _____ Date: _____ Phone: _____ Fax: _____