MRADLS
Standard Written Order (SWO)
(Mobility-Related Activities to Daily Living)

Prism Health Care Services, Inc.
1337 Basswood Road
Schaumburg, IL 60173-4536
Phone: 847-310-4730 *3
Fax: 872-469-1673

Order Date: _____

Patient Name: _____ Phone: _____

Date of Birth: _____ Cell Phone: _____

Diagnosis: 1 _____ 2 _____ 3 _____

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

Cane (E0100)	☐			
Quad Cane (E0105)	☐			
Crutches (Select Type)	☐	**Forearm Pair (E0110)**	**or**	☐ **Underarm Pair (E0114)**
Knee Walker (E0118)	☐	**Not covered by Medicare. Circle non-weight bearing lower extremity. Left Right**		
Walker-Pick up Adult or Junior (w/o wheels)	☐	**300 lbs. or under (E0135)**	**or**	☐ **Over 300 lbs. (E0148)**
Walker-with 5" Wheels Adult or Junior w/wheels	☐	**300 lbs. or under (E0143)**	**or**	☐ **Over 300 lbs. (E0149)**
Walker Leg Extension (E0158)	☐	**Must be over 6 Feet Tall for this item to be covered.**		
Walker Platform Attachment (E0154)	☐	**Medical necessity for the attachment(s) must be documented in the notes. Indicate the side(s) requiring the platform(s). Right Left Both**		

PLEASE SUBMIT THIS FORM ALONG WITH A FACE TO FACE, AND CLINICAL NOTES, i.e doctors, progress, nurses, occupational therapy, and/or 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.

Coverage Criteria

The following criteria must be met, and proper documentation must be received in order for the item to be deemed medically necessary.

* The beneficiary has a mobility limitation that significantly impairs his/her ability to participate in one or more MRADL, such as toileting, feeding, dressing, grooming and bathing 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 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 why the walker and wheelchair are needed.

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.