IN-STEP MOBILITY PRODUCTS PHONE: 800-558-7837 FAX: 847-676-1202

Detailed Order / Prescription

Effective Date:_____/_____/_____

Patient Name: _____ Patient Phone: _____

D.O.B._____ Length of Need:_____ (99 months=lifetime)

Diagnosis & ICD10 Code(s)_____,_____

Please answer the following questions to determine medical necessity for insurance coverage

Yes / No Does the patient have a severe walking problem that places him/her at heightened risk of morbidity or mortality without a walking-aid?

Yes / No Will a cane or crutch be sufficient in preventing your patient from falling and injuring himself/herself?

Yes / No Will a standard walker be sufficient for preventing your patient from falling and injuring himself/herself?

Yes / No Are you prescribing the U-Step Neuro Walker (HCPCS Code E0147, produced by In-Step Mobility), because your patient has a severe neurological condition or limited use of a hand, and requires this product to safely ambulate and prevent serious injury due to risk of falling?

Yes / No Will your patient's mobility deficit be sufficiently resolved by using a U-Step Neuro Walker?

What products are you prescribing for your patient?

☐ **Standard**
U-Step Neuro Walker
E0147 + E0156

☐ **Platform**
U-Step Neuro Walker
E0147 + E0156 + E0154

☐ **Press Down**
U-Step Neuro Walker
E0147 + E0156

☐ **Cueing Module (Laser and Auditory Cue for Parkinson's freezing)**

Physician printed name: _____

NPI #: _____ Phone: _____ Fax: _____

Physician Address:_____ City:_____ State: _____

By signing below, I authorize the use of this document as a legal prescription, and I certify that the above prescribed equipment is medically necessary, reasonable, accurate and complete and is not being prescribed for convenience. I will maintain an original signed copy of this order in my medical records and make it available to Medicare, their authorized agents or other insurer, if required.

Physician Signature:_____ Date: _____