Phone: 586-778-2500
Fax: 866-565-5190

Equipment Request Form

Variable Wheel Resistance Walker
(U-Step)

Per Medicare requirements, a **SIGNED PHYSICIAN'S ORDER is required PRIOR TO delivery**. Please answer all questions below and return to Renaissance Medical. In addition, please make sure a signed copy is kept in your patient's file.

Patient Full Name: _____ Date of Birth: _____

Address City/St/Zip: _____

Medicare # _____ Other Ins Type & # _____

Referring Facility/Name: _____ Contact Name: _____

Deliver To: ☐ Facility ☐ Home Requested Delivery Date: _____ Approx Time: _____

Multiple Braking System Variable Wheel Resistance Walker (E0147) 1, 2, 3, 4 AND 5 MUST be YES

*A written script on original dr. notepad (i.e. script pad, letterhead, etc.) dated **PRIOR-T**O the date of delivery stating the following *(example below)*:

1. Patient Name
2. Severe neurologic disorder or condition causing the restricted use of one hand
3. Patient tried a standard wheeled walker and was unsuccessful.

1. Does the patient have a **mobility limitation** that significantly **impairs ability** to participate in one or more MRADL in the home? ◯Y ◯N

2. Is the patient able to **safely** use the **U-Step**? ◯Y ◯N

3. Can the functional mobility **deficit** be sufficiently **resolved** with the use of a **U-Step**? ◯Y ◯N

4. Does the patient have a **severe neurological** disorder **or** other condition causing the **restricted use of one hand**? ◯Y ◯N

5. Has the patient tried **unsuccessfully** to use a standard walker with wheels? ◯Y ◯N

Written Script Example: **Length of Need (Months) (99=Lifetime): _____**

Patient Name: John Doe, Dx: Parkinson's Disease
My patient Mr. Doe has a severe neurological condition that is progressive in nature. My patients gait has been severely affected by this condition. Therefore, after trying a standard wheeled walker, it is apparent my patient requires an advanced walking aid with multiple braking system and variable wheel resistance to ambulate. I am prescribing the U-Step walking stabilizer.

Diagnosis(es) that qualify the need of item delivered: _____

Ordering Physician, PA, or Nurse Practitioner Name (Please Print): _____

Ordering Physician, PA, or Nurse Practitioner Signature: _____ Date: _____/_____/_____

NPI: _____

Please Fax This Page with Patient Demographics To: 1▪866▪565▪5190