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Letter of Medical Necessity

This form is to be completed by your Physician/ Health Care Provider/ Medical Facility. You may then submit this form when filing your insurance claim.

Product: Knee walker / Knee Scooter

HCPCS Code (E0118) Crutch Substitute/ Alternative lower leg platform, with or without wheels

Patient's Full Name: _____

Date Needed: _____ Expected Weeks Needed: _____

Diagnosis:

_____ DX Code: _____

_____ DX Code: _____

_____ DX Code: _____

☐ Patient has fracture dislocation tendon rupture surgery, which requires absolute non- weight bearing to maximize chance for optimal healing and recovery. The patient is unable to perform daily living task with crutches but can do so with this equipment.

☐ Patient has an ulcer infection, which requires which requires absolute non-weight bearing to maximize chances for optimal healing and recovery. The patient is unable to utilize crutches effectively or is unable to perform daily living tasks with crutches but can do so with this equipment.

☐ Patient has a neurological or musculoskeletal condition, making the patient unable to bear weight on one foot safely. This equipment will greatly increase the patient's ability to function independently.

☐ Other _____

I hereby certify that this equipment is medically necessary.

Signature: _____ Date: _____

Print Name: _____ Phone: _____