Letter of Medical Necessity for Knee Scooter

A Leg Up Bay Area
3248 Briggs Ave B
Alameda, California 94501
Phone: (510) 523-4143 Fax: (510) 523-4829
E-Mail: alegup@comcast.net
EIN: 82-2892881

HCPC: Code EO118 – Crutch Substitute

Patient: _____

Date of Need: _____**Expected Duration of Need:** _____

Diagnosis: _____

_____**Code:** _____

_____**Code:** _____

_____**Code:** _____

____Patient has *fracture dislocation tendon rupture surgery* which requires **absolute non weight bearing** maximize chance for optimal healing and recovery. This patient is unable to utilize crutches effectively, or is unable to perform tasks of daily living with crutches, but can do so with the knee scooter.

____Patient has an *ulcer infection* which requires **absolute non weight bearing** to maximize chance for optimal healing and recovery. This patient is unable to utilize crutches effectively, or is unable to perform tasks of daily living with crutches, but can do so with the knee scooter.

____Patient has a *neurologic musculoskelatal* condition which makes him/her unable to effectively or safely bear weight on one foot. The knee scooter will greatly increase this person's ability to function independently.

____Other: _____

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I hereby certify that this device is medically necessary.

_____ _____

Signature Date