



ALLSTATE DME LLC
4949 N. McColl Rd.
McAllen, TX 78504

Phone (956) 992-8866

FAX (956) 287-8586

Provider No. 6385310001

PHYSICIAN: _____

UPIN _____ **NPI** _____

Phone _____

PATIENT: _____

Phone _____

DOB _____

Policy: _____

Initial Date _____

Revised Date _____

Recertification

Length of Need : _____

DIAGNOSIS

ICD-9 Code

Description

_____	_____
_____	_____
_____	_____
_____	_____

EQUIPMENT/SERVICES

Qty

Proc. Code

Item Name/Narrative

_____	_____	_____
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ADDITIONAL MEDICAL INFORMATION (circle one please)

1. Does the patient have a mobility limitation that impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADL) in the home? Y / N

A mobility limitation is one that:

- Prevents the patient from accomplishing the MRADL entirely, or
- Places the patient at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform the MRADL, or
- Prevents the patient from completing the MRADL within a reasonable time frame;

2. Is the patient is able to safely use the walker? Y / N

3. Can the functional mobility deficit be resolved with use of a walker? Y / N

4. Does the patient require greater stability than can be provided with a cane or crutch? Y / N

5. Does the patient's height exceed 6ft? Y / N

6. How much does the patient weigh? _____ Lbs

7. Does the patient have a severe neurologic disorder or other condition causing the restricted use of one hand? Y / N

Dear Physician,

The following information was provided to our office as part of the order intake process. Please confirm that the information is correct. If the information is correct it needs to be inserted into the attached Written Order form. Any changes or corrections should also be inserted into the attached form. Once all sections of the Written Order are completed, please sign, date and fax the form back to our office **(956) 287-8586**. Thank you.

Clinician Signature _____

Date _____