Letter of Medical Necessity for *Roll-A-Bout*

HCPCS: CODE - E 0118 CRUTCH SUBSTITUTE, LOWER LEG PLATFORM, WITH OR WITHOUT WHEELS

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 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 *Roll-A-Bout.*

___ 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 *Roll-A-Bout*.

___ Patient has a *Neurologic Musculoskelatal* condition which makes him/her unable to effectively or safely bear weight on one foot. The *Roll-A-Bout* will greatly increase this person's ability to function independently.

___ Other _____

_____

_____

I hereby certify that this device is medically necessary.

_____ _____

Signature Date