

Letter of Medical Necessity for Rolling Knee Scooter

HCPC Code: E0118 - Crutch Substitute, with or without wheels

To Be Completed by **Physician/Health Care Provider/Medical Facility** and mailed/faxed to:

Scot About, LLC
P.O. 886
Helotes, Texas 78023-0886
<http://scootaboutkneescooters.com>

Email: info@scootaboutkneescooters.com

Phone: 210-695-1136 FAX: 210-695-5393

NPI#: 1174791578 Tax ID/EIN: 84-1710038

Patient's Full Name: _____

Date Needed: _____ Expected Duration of Rental: _____

Diagnosis _____

Code: _____ Code: _____ Code: _____ Code: _____

(Check one)

_____ Patient has fracture dislocation tendon rupture surgery, which requires absolute non-weight bearing to maximize chances 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 rolling knee scooter.

_____ Patient has an ulcer infection, which requires absolute non weight bearing to maximize chances 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 rolling knee scooter.

_____ Patient has a neurological or musculoskeletal condition, making him/her unable to bear weight on one foot safely. The rolling knee scooter will greatly increase this person's ability to function independently.

_____ Other _____

I hereby certify that this device is medically necessary.

Signature _____ Date _____

Address: _____