

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 Musculoskeletal* 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