



Medical Necessity Letter for Easy Crutch

HCPCS: E0118 – 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 an Easy Crutch.

_____ 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 Easy Crutch.

_____ Patient has a *neurologic musculoskeletal condition* which makes him/her unable to effectively of safely bear weight on one foot. The Easy Crutch will greatly increase this person's ability to function independently.

_____ Patient has _____

I hereby certify that this device is medically necessary.

_____ Date: _____

Physician Signature