WRITTEN DME ORDER PRIOR TO DELIVERY

Order Date: _____

Patient Name:_____ **Patient DOB:**_____

Patient Address:_____ **SSN#**_____

City:_____ **Patient Telephone #**_____

State:_____ **Prognosis:**_____

Diagnosis:_____ **Length Of Need:**_____ **(99) Months = Lifetime** **Ht/Wt**:_____
(icd-10)

Indicate if criteria A, B, C, D and E are met

- ☐ A. The beneficiary has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living.
- ☐ B. The beneficiary's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker.
- ☐ C. The beneficiary's home provides adequate access between rooms, maneuvering space, and surfaces for use of the manual wheelchair that is provided.
- ☐ D. Use of the wheelchair will significantly improve the beneficiary's ability to participate in MRADLs and the beneficiary will use it on a regular basis in the home.
- ☐ E. The beneficiary has not expressed an unwillingness to use the manual wheelchair that is provided in the home.

AND F or G

- ☐ F. The beneficiary has sufficient physical and mental capabilities needed to safely self-propel the wheelchair that is provided in the home during a typical day.
- ☐ G. The beneficiary has a caregiver who is available, willing, and able to provide assistance with the wheelchair.

☐ **K0001**		**Description: Standard Manual Wheelchair w/ manual accessory seat 20" - 24"**	**Qty: 1**
☐ **K0002**		**Description: Hemi Manual Wheelchair (Lowered) w/ manual accessory seat 20" - 24"**	**Qty: 1**
☐ **K0003**		**Description: Lightweight Manual Wheelchair w/ manual accessory seat 20" - 24"**	**Qty: 1**
☐ **K0006**	**Wt: >250 Lbs.**	**Description: 22" Heavy Duty Manual Wheelchair w/ manual accessory seat 20" - 24"**	**Qty: 1**
☐ **K0007**	**Wt: >300 Lbs.**	**Description: 24" Heavy Duty Manual Wheelchair w/ manual accessory seat 20" - 24"**	**Qty: 1**

Wheelchair Accessories

- ☐ Foam wheelchair seat cushion
- ☐ General use back cushion
- ☐ Elevating wheelchair leg rests
- ☐ Wheelchair anti-tipping devices (pair)
- ☐ Skin protection wheelchair seat cushion adjustable (Less than 22")
- ☐ Wheel lock extentions (pair)
- ☐ Safety Belt
- ☐ Cylinder Tank Carrier
- ☐ Skin protection wheelchair seat cushion adjustable (22" or greater)

☐ **E1038**	**Transport Wheelchair**		☐ **E0100**	**Straight Cane**	
☐ **E0143**	**Walker, folding w/ wheels**	☐ **Seat Attachment**	☐ **E0105**	**Quad Cane (Small) (Large) Base**	
☐ **E0154**	**Platform attachmend (L R)**		☐ **E0149**	**Folding extra wide walker w/ wheels (>300lbs)**	

I, the undersigned, certify that the above prescribed equipment/supplies is medically necessary for part of my treatment for this patient.
In my opinion, the equipment prescribed is reasonable and necessary for accepted standards of medical practice and treatment
of this patient's condition and has not been prescribed as "conveniance equipment".

Date Patient Last Seen: _____

Physician Name:_____

Physician Address:_____ **Physician Telephone #** _____

City:_____ **State:**_____ **Zip Code:**_____ **NPI #**_____

Physician Signature:_____ **Date:**_____