Written Order Prior to Delivery
Manual Wheelchairs
(Standard, Lightweight, Heavy Duty)
General Use Cushion (E2601)

Phone: 860-674-1601
Fax: 888-897-3010

Per Medicare requirements, a **SIGNED PHYSICIAN'S ORDER is required PRIOR TO delivery**. Please answer all questions below and return to DME Living Well, In addition, please make sure a signed copy is kept in your patient's file. As of **July 1, 2013**, you must forward documentation of a face to face evaluation before delivery can be made.

Patient Full Name: _____ Date of Birth: _____/_____/_____

Address City/St/Zip: _____

Medicare #_____Other Ins Type & # _____

Referring Facility:_____Contact Name:_____Phone: _____

All Manual Wheelchairs	**Requires 1 THRU 5 to be YES AND 6 OR 7 to be YES**
Standard Wheelchair (K0001)	
Hemi Height Wheelchair (K0002)	Qualifies for **Standard Wheelchair** but requires a lower seat height because of short stature.
Lightweight (K0003)	Qualifies for a **Manual Wheelchair** (above) AND **a) Cannot self-propel** in a **standard wheelchair** in the home. AND b) The patient **can and does self-propel** in a **lightweight wheelchair**.
Heavy Duty(K0006)	Qualifies for a **Manual Wheelchair** AND weighs GREATER THAN 250lbs
Extra Heavy Duty (K0007)	Qualifies for a **Manual Wheelchair** AND weighs GREATER THAN 300lbs
Transport Chair (E1038)	Covered as an alternative to Standard Wheelchair
General Use Cushion (E2601)	

1. The patient has a mobility limitation that greatly impairs ability to participate in MRADLs. _____Y_____N
2. The patient's mobility limitation cannot be sufficiently resolved by the use of cane or walker. _____Y _____N
3. The patient's home provides adequate access for use of the manual wheelchair that is provided. ____Y ____N
4. Wheelchair will improve the patient's ability to participate in MRADLs. To be used in home on a regular basis. __Y__N
5. The patient has is willing to use the manual wheelchair that is provided in the home. __Y____N
6. The patient has sufficient upper extremity function to safely self-propel the manual wheelchair. _____Y_____N
7. The patient has a caregiver who is available, willing, and able to provide assistance. _____Y_____N

Height:_____Weight:_____Length of Need (99=Lifetime): ____

Diagnosis (es) that qualify the need of itemdelivered: _____

Ordering Physician, PA, or APRN (Please Print): _____

Ordering Physician, PA, or APRN Signature:_____Date:__/___/___

NPI: _____

For an item to be covered by insurance a written signed & dated order/RX must be received by DME LIVING WELL from the physician. The physician is also acknowledging that he has had a face to face consolation with the patient within six months of when the order was placed.

Please Fax This Page with Patient Demographics to: 888-897-3010