MOBILITY EQUIPMENT ORDER

Patient Name: _____ **DOB:** _____

Address: _____ **Phone #:** _____

Insurance ID #: _____

Check all that apply:

POWER	MANUAL
□ K0823 Power Wheelchair □ E2365 U1 Battery QTY: 2 □ E0973 Adjustable Armrests QTY: 2	□ Wheelchair (circle one): Standard / Lightweight / Heavyduty □ Transport Chair □ Swingaway Footrests QTY: 2 □ Wheelchair Back Cusion
□ K0821 Power Scooter □ E2365 U1 Battery QTY: 2	□ 4-Wheel Walker/Rollator □ Walker Seat □ Walker Brakes QTY: 2
	□ Knee Scooter
□ E0295 Semi-Electric Hospital Bed □ E0305 Hospital Bed Half Rails QTY: 2 □ E0277 Air Pressure Mattress	□ Crutches (circle one): Forearm / Underarm
	□ Other: _____

DIAGNOSIS/ICD-10 CODE(S): _____

Prescriber Name: _____ **NPI:** _____

Office Address: _____ **Phone #:** _____

Prescriber Signature: _____ **Date:** _____

INLAND
DURABLE MEDICAL EQUIPMENT & MEDICAL SUPPLY

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