Detailed Written Order for Manual Wheelchair

Medicare regulations mandate that all of the following elements be included on the prescription/written order for a Manual Wheelchair. **Please fax this form back along with the relative chart notes from the face-to-face exam that relates to the manual wheelchair being ordered.**
Fax to Mobility & More at 704-821-7777.

Beneficiary Name: _____

HICN Number: _____ Date of Birth: _____

Description of the item ordered: (check all that apply)

☐ Light Weight Manual Wheelchair * K0004		☐ Wheelchair Cushion E2601	☐ Seat Belt E0978
☐ Standard Weight Manual Wheelchair K0001		☐ Wheelchair Back Cushion E2611	☐ Heel Loops (2) E0951
☐ Heavy Duty Manual Wheelchair K0007		☐ Adjustable Ht Arms (pair) E0973	☐ Anti Tippers (2) E0971
Manufacture:		☐ Reclining Back E1226	☐ Other:
Model #:		☐ Elevating Leg Rest (pair) E0990	

***By selecting this I certify that:** The beneficiary can self-propel the wheelchair while engaging in frequent activities in the home that cannot be performed in a standard wheelchair. I further certify that the patient will spend at least two hours per day in the chair.

Accessories needed for Wheelchair that has been Ordered: (Circle Y or N)

Does the patient have a need for arm height different than that available using nonadjustable armrests?
Adjustable Height Armrest: Y N

Does the patient have quadriplegia, a fixed hip angle, a trunk cast or brace, excessive extensor tone of the trunk muscles or a need to rest in a recumbent position two or more times during the day?
Reclining Back: Y N

Does the patient have a cast, brace or a musculoskeletal condition, which prevents 90 degree flexion of the knee, or does the patient have significant edema of the lower extremities that require elevating leg rests, or is a reclining back ordered?
Elevating Leg Rest: Y N

Date of completion of the face-to-face examination report if applicable: _____

Pertinent diagnoses/conditions and or ICD10 codes that relate to the need for the item or items ordered:

_____

Length of need in months: (99 = lifetime) _____

Physician's Name: _____ NPI # _____

Physician's Signature: _____ Date: _____