Detailed Product Description

Patient Name _____ Medicare/Insurance # _____

Patient Phone # _____

Product Type _____ DOB _____

Manufacture _____ Model _____

Qty.	HCPCS Code	Product Description	Charge Amount	Medicare Allowable
1	K0825	Motorized Wheelchair (HD)	$4500.00	$4251.25
2	E0990	Elevating Leg-Rest, Each	$110.00	$98.36
2	E0973	Adjustable Height Armrest, Each	$125.00	$92.25
2	E2365	22-NF Batteries	$115.00	$100.38
___	_____	_____	_____	_____
___	_____	_____	_____	_____
___	_____	_____	_____	_____

The signature below is to ensure that the physician is well informed about the equipment being provided to the patient and has the information necessary to provide feedback to the supplier as necessary about any safety or functional concerns. This form must be signed and dated by physician before product is delivered. You may fax this form to 704-821-7777.

Any questions or comments, please call us at 704-821-7777.

Physician Signature _____ Date _____

Revised 06/19