

MANUAL WHEELCHAIR STANDARD WRITTEN ORDER



Please fax to:
Anchorage (907) 274-0773
Fairbanks (907) 458-8914
Soldotna (907) 260-3757
Wasilla (907) 357-7883
or email to:
dme@procarehm.com

Patient Name, Address, Telephone & Insurance ID#:

Phone: _____ **Ins ID#:** _____

Patient DOB: _____ **Sex:** _____ **(M/F)**

Refer to the wheelchair coverage criteria sheet for all required documentation.

Date of last visit: _____

Order Date: _____

Diagnosis and Code: _____

Length of Need (# of months): _____ 1-99 (99=lifetime)

Patient Height: _____ in. Patient Weight: _____ lbs.

BASE EQUIPMENT: Select One - all basic chairs come w/standard footrests

Wheelchair, Standard (K0001), 250lb max

Wheelchair, Hemi Height (K0002), 250lb max

Wheelchair, Light Weight (K0003), 250lb max

Wheelchair, High Strength, Light Weight (K0004), 250lb max

Wheelchair, HD (K0006), 300lb max

Wheelchair Extra HD (K0007), 450lb max

Pediatric wheelchair w/standard footrests

Pediatric wheelchair with elevating leg rests

*Standard pediatric chairs do not come with accessories other than listed above.

Transport Chair (E1038), 250 lb max

Transport Chair, Heavy Duty (E1039), 450 lb max

*Transport chairs do not come with additional accessories

STANDARD ACCESSORY PACKAGE (INCLUDES ALL OF THE FOLLOWING): Select one checkbox

Anti-tippers, right & left (E0971), Basic Back Cushion (E2611), Basic Cushion (E2601/E2602)

Other: _____

OPTIONAL ACCESSORIES: Additional criteria is required

Seat Belt (E0978)

Elevating Leg Rests, (K0195)

Elevating Leg Rests, Telescoping (K0053) Left Side Right Side

Note: Telescoping ELR's are used for tall patients (6'2") & speciality casts

Brake Extensions (E0961) Left Side Right Side

Transfer Board (E0705)

Reclining Back (E1226)

Oxygen Tank Holder

Amputee Stump Support Left Side Right Side

Specialty cushions - MUST meet additional justification to qualify

Skin protectant cushion (E2603/E2604/E2622/E2623)

Positioning seat cushion (E2605/E2606)

Skin protectant, positioning seat cushion (E2607/E2608/E2624/E2625)

PROVIDER CERTIFICATION:

I, the patient's treating provider, certify the medical necessity of these items for this patient and maintain medical records reflecting the medical justification and care provided.

Provider's Signature : _____ Date: _____ NPI: _____

Provider's Name: _____ Telephone: _____