

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
- Wheelchair, Pediatric (E1236)
- Other: _____

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 (E1225)
- Oxygen Tank Holder

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: _____