

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)
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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

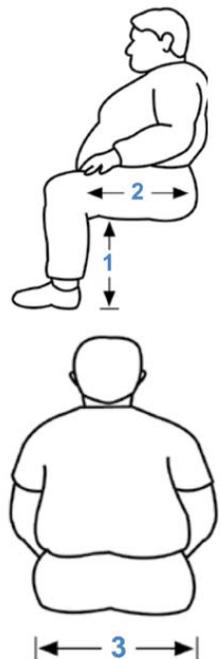
- Skin protectant cushion (E2603/E2604/E2622/E2623)
- Positioning seat cushion (E2605/E2606)
- Skin protectant, positioning seat cushion (E2607/E2608/E2624/E2625)

Additional Measurement Options (See Below for Details)

- 1) _____
- 2) _____
- 3) _____

Additional Measurement Options (recommended)

- 1.) Measuring the **tibial length/lower leg length/seat to floor height** is used for patients who self-propel with their feet.
- 2.) **Seat depth/femur length** measurements are taken from the back of the knee to the SI joint
- 3.) Width of the wheelchair is determined by **hip size**. We want the patient to be seated and measure from the outside of each hip at its fluffiest point.



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: _____