MANUAL WHEELCHAIR STANDARD WRITTEN ORDER

PROCARE HOME MEDICAL

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 documention.

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), 250lb max
- ☐ Transport Chair (E1038), 250lb max
- ☐ Transport Chair, Heavy Duty (E1039), 450lb max

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
- ☐ 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: _____