PHYSICIAN'S ORDER FOR MOBILITY EQUIPMENT AND ACCESSORIES

STARTING DATE OF ORDER: _____
(if different than the signed date)

Patient Information:

Name: _____ **Phone:** (____) _____ **DOB:** _____ **Height:** _____ **Weight:** ____

DIAGNOSIS INFORMATION

Diagnoses: _____ _____

Length of need: _____ Months

Date of Face to Face Evaluation _____

Per Medicare Coverage guidelines a Wheelchair will be covered if:

1) The patient has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADLs) such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home. A mobility limitation is one that:

A. Prevents the patient from accomplishing an MRADL entirely, or
B. Places the patient at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL; or
C. Prevents the patient from completing an MRADL within a reasonable time frame.

2) The patient's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker.

3) The patient's home provides adequate access between rooms, maneuvering space, and surfaces for use of the manual wheelchair that is provided.

4) Use of a manual wheelchair will significantly improve the patient's ability to participate in MRADLs and the patient will use it on a regular basis in the home.

5) The patient has not expressed an unwillingness to use the manual wheelchair that is provided in the home.

6) The patient has sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the manual wheelchair that is provided in the home during a typical day. Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function, or the patient has a caregiver who is available, willing, and able to provide assistance with the wheelchair.

Standard - Heavy Duty – Hemi **Initials:**

☐ K0001, K0006 (*patient weight over 300 lbs.)
K0007 *patient weight over 350 lbs.

☐ K0002 – Hemi – Patient Requires Lower seat to floor height _____

Lightweight

**Patient cannot self-propel Standard Weight chair. _____

☐ K0003 – Up to patient weight 300 lbs.

Seat Width

☐ E2201– Wide Seat – 20-22 inch Hip Width: _____

☐ E2202– Extra Wide Seat – 24 inch

Seat Depth

☐ E2203– Tall Seat – 20 inch Leg Length:_____

☐ E2204– Extra Tall Seat – 22 inch

Accessories **Initials:**

☐ E0971 – Pair of Anti-tippers _____

☐ E0973 – Pair of Adjustable Height Armrests _____

☐ E0978 – Seat Belt _____

☐ E0961 – Pair of Brake Extensions _____

☐ E2601, E2602 – General Seat Cushion (E2602 – 22" Width) _____

☐ E2611, E2612 – General Back Cushion (E2612 – 22" Width)_____

☐ E2603, E2604 –Skin Protection Seat (E2604 – 22" Width) _____

☐ E2605, E2606 – Positioning Seat (E2606 – 22" Width) _____

☐ K0195 – Pair of Elevating Leg Rests _____

Reclining Back

☐ E1226 – Wheelchair with Reclining back to accommodate patients needs inside the home

By signing below I assert I am the treating physician for this patient and this patient meets all **6** of the above criteria to qualify for Medicare Coverage for this item. Additionally, I understand:

- Supplier-produced records, even if signed by the ordering physician, and attestation letters (e.g. letters of medical necessity) are deemed not to be part of a medical record for Medicare payment purposes.
- Templates and forms, including CMS Certificates of Medical Necessity, are subject to corroboration with information in the medical record.

Physician Name_____ Phone:_____ Fax:_____ NPI_____

Corroborating medical records attached: Physician Signature:_____ Date:_____