

Account Executive (circle one) - Frank Trammell - (704) 579-7070; Ashley Kemp - (704) 564-6982; Adrian Johnson - (704) 698-5296; Main Office (704) 846-7503; Main Fax (704) 846-7911

Manual Wheelchair Detailed Written Order Prior to Delivery (DWOPD)

PATIENT'S NAME: _____ PHONE: _____

PATIENT'S HEIGHT: _____ WEIGHT: _____ DATE OF BIRTH: _____

SNF/REHAB/HOSPITAL DISCHARGE DATE: _____

PRIMARY CARE PHYSICIAN'S NAME: _____

DIAGNOSIS: _____

LENGTH OF NEED: _____

The items listed below REQUIRE office visit notes & a physician's SIGNED order prior to delivery.

Please check one:

- STANDARD WHEELCHAIR (K0001)
- HIGH STRENGTH LIGHTWEIGHT WHEELCHAIR (K0004)
- LIGHTWEIGHT WHEELCHAIR (K0003)
- HEAVY DUTY WHEELCHAIR (PATIENT'S WEIGHT IS BETWEEN 251-300LBS) (K0006)
- EXTRA HEAVY DUTY WHEELCHAIR (PATIENT'S WEIGHT IS OVER 301LBS) (K0007)
- FULLY MANUAL RECLINING BACK (E1226), ELEVATING LEG RESTS (K0195), WITH A LIGHTWEIGHT WHEELCHAIR (K0003)

Usual and Customary Manual Wheelchair Accessories - Please check all that apply and justify in your patient notes

<p><u>Basic Accessories</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> ADJUSTABLE HEIGHT ARMS <input type="checkbox"/> ANTI-TIPPERS <input type="checkbox"/> BACK CUSHION (E2611/E2612) <input type="checkbox"/> SEAT CUSHION (E2601/E2602) <input type="checkbox"/> HEEL LOOPS <input type="checkbox"/> WHEEL LOCK (BRAKE) EXTENSIONS <input type="checkbox"/> SEAT TO FLOOR HEIGHT LESS THAN 17" (K0056) 	<p><u>Additional Accessories</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> ARM TRAY <input type="checkbox"/> ARM TROUGH <input type="checkbox"/> HARDWARE FOR ARM TROUGH <input type="checkbox"/> ARTICULATING ELEVATING LEG RESTS <input type="checkbox"/> ELEVATING LEG REST <input type="checkbox"/> SAFETY BELT <input type="checkbox"/> STUMP PAD/RESIDUAL LIMB SUPPORT
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*Per Medicare guidelines, each item checked above
MUST be justified in your face-to-face notes.*

Physician's Printed Name: _____ Length of Need: _____

Physician's Signature: _____

Signature Date: _____

NPI# _____

Start/Date of Order*: _____

Co-signing Physician may use billing code G0454 for cosigning face-to-face documentation.

SUBSTITUTION PERMITTED TO PROVIDE QUALIFYING SERVICE

* - MUST have date of order (or start date) in addition to physician's signature date.