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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: _____

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

Please check one:

Seat Size: Width: _____ Depth: _____ Seat to Floor: _____
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STANDARD WHEELCHAIR (K0001)
 STANDARD HEMI WHEELCHAIR (K0002)
 LIGHTWEIGHT WHEELCHAIR (K0003)
 HIGH STRENGTH LIGHTWEIGHT WHEELCHAIR (K0004)
 ULTRA LIGHTWEIGHT WHEELCHAIR (K0005)
 HEAVY DUTY WHEELCHAIR (PATIENT'S WEIGHT IS BETWEEN 251-300LBS) (K0006)
 EXTRA HEAVY DUTY WHEELCHAIR (PATIENT'S WEIGHT IS OVER 301LBS) (K0007)
 TRANSPORT CHAIR

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

SEAT AND BACK CUSHIONS:

<input type="checkbox"/> GENERAL USE SEAT CUSHION (E2601)	<input type="checkbox"/> SKIN PROTECTION & POSITIONING SEAT CUSHION (E2607)
<input type="checkbox"/> GENERAL USE SEAT CUSHION WIDTH 22" OR GREATER (E2602)	<input type="checkbox"/> SKIN PROTECTION & POSITIONING SEAT CUSHION WIDTH 22" OR GREATER (E2608)
<input type="checkbox"/> SKIN PROTECTION SEAT CUSHION (E2603)	<input type="checkbox"/> SKIN PROTECTION SEAT CUSHION, ADJUSTABLE, WIDTH LESS THAN 22" (E2622)
<input type="checkbox"/> SKIN PROTECTION SEAT CUSHION WIDTH 22" OR GREATER (E2604)	<input type="checkbox"/> SKIN PROTECTION & POSITIONING SEAT CUSHION, ADJUSTABLE, WIDTH LESS THAN 22" (E2624)
<input type="checkbox"/> POSITIONING SEAT CUSHION (E2605)	<input type="checkbox"/> GENERAL USE BACK CUSHION (E2611)
<input type="checkbox"/> POSITIONING SEAT CUSHION WIDTH 22" OR GREATER (E2606)	<input type="checkbox"/> GENERAL USE BACK CUSHION WIDTH 22" OR GREATER (E2612)

Basic Accessories	Additional Accessories
<input type="checkbox"/> ADJUSTABLE HEIGHT ARMS - LENGTH: DESK FULL	<input type="checkbox"/> ARM TRAY - HALF FULL (with HARDWARE)
<input type="checkbox"/> ANTI-TIPPERS	<input type="checkbox"/> ARM TROUGH - R L BOTH (with HARDWARE)
<input type="checkbox"/> HEEL LOOPS (BASIC FOOTREST)	<input type="checkbox"/> ARTICULATING ELEVATING LEG RESTS - R L BOTH
<input type="checkbox"/> WHEEL LOCK (BRAKE) EXTENSIONS	<input type="checkbox"/> ELEVATING LEG REST - R L BOTH
<input type="checkbox"/> SEAT TO FLOOR HEIGHT LESS THAN 17" OR GREATER THAN 21" (K0056)	<input type="checkbox"/> RECLINING BACK, FULLY MANUAL, with ELEVATING LEG RESTS
<input type="checkbox"/> SEAT DEPTH 20", BUT LESS THAN 22" (E2203)	<input type="checkbox"/> SAFETY BELT
<input type="checkbox"/> SEAT DEPTH 22" - 25" (E2204)	<input type="checkbox"/> SEAT WIDTH ≥ 20", BUT LESS THAN 24" (E2201)
	<input type="checkbox"/> SEAT WIDTH 24"-27" (E2202)
	<input type="checkbox"/> STUMP PAD/RESIDUAL LIMB SUPPORT - R L BOTH

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: _____

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 start/date of order