Hayat
Home Medical Equipment

WHEELCHAIR PRESCRIPTION / DETAILED WRITTEN ORDER (DWO)

3518 W. 95th Street, Evergreen Park, IL 60805
Phone: (708) 422-2300
Fax: (708) 422-5966

PLEASE FAX OFFICE NOTES ALONE WITH THIS PRESCRIPTION

PATIENT INFORMATION

Patient Name: _____

Date of Birth: ___ /___ /_____ **Height:** _____ **Weight:** _____

Address: _____

Phone: _____

Insurance: _____

Member ID: _____

DIAGNOSIS

Primary ICD-10 Code: _____

Secondary ICD-10 Code(s): _____

PRESCRIPTION

Standard Wheelchair (Select One)

□ **K0001 Standard Wheelchair**

□ **K0003 Lightweight Wheelchair**

□ **K0007 Extra Heavy Duty Wheelchair**

MEDICAL NECESSITY

Patient has a mobility limitation significantly impairing one or more Mobility-Related Activities of Daily Living (MRADLs), including:

□ **Toileting**

□ **Feeding**

□ **Dressing**

□ Grooming

□ Bathing

□ Ambulation

Patient:

□ Cannot safely use a cane.

□ Cannot safely use a walker.

□ Has sufficient upper extremity function to self-propel.

□ Requires caregiver assistance.

□ Home environment accommodates wheelchair use.

LENGTH OF NEED

□ 99 Months (Lifetime)

□ _____ Months

PHYSICIAN CERTIFICATION

I certify this equipment is medically necessary for the treatment of this patient's condition and is reasonable and necessary under accepted medical standards.

Physician Name: _____

NPI: _____

Phone: _____

Fax: _____

PHYSICIAN SIGNATURE

Signature: _____ **Date:** ___/___/_____

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