D W MEDICAL SUPPLY;
1524 Centinela Ave
Inglewood CA 90302
(310) 330-0162 * Fax (310) 330-0199

Detailed Written Order

Medicare regulations mandate that all of the following elements be included on the prescription/written order for a Manual Wheelchair. Also, please provide any chart notes that relate to the equipment being ordered.

Beneficiary Name: _____

Medicare Number: _____ Date of Birth: _____

Description of the item ordered: (check all that apply)

☐ Light Weight Manual Wheelchair		☐ Wheelchair Cushion	☐ Seat Belt
☐ Standard Weight Manual Wheelchair		☐ Wheelchair Back Cushion	☐ Heel Loops
☐ Heavy Duty (Bariatric) Manual Wheelchair		☐ Adjustable Height Armrest	☐ Anti Tippers
Manufacture:		☐ Reclining Back	☐ Other:
Model #:		☐ Elevating Leg Rest	

Accessories needed for Wheelchair that has been Ordered: (Circle Y or N)

Does the patient have a need for arm height different than that available using nonadjustable armrests?
Adjustable Height Armrest: Y N

Does the patient have quadriplegia, a fixed hip angle, a trunk cast or brace, excessive extensor tone of the trunk muscles or a need to rest in a recumbent position two or more times during the day?
Reclining Back: Y N

Does the patient have a cast, brace or a musculoskeletal condition, which prevents 90 degree flexion of the knee, or does the patient have significant edema of the lower extremities that require elevating leg rests, or is a reclining back ordered?
Elevating Leg Rest: Y N

Date of completion of the face-to-face examination report if applicable: _____

Pertinent diagnoses/conditions and or ICD9 codes that relate to the need for the item or items ordered:

_____

Length of need in months: (99 = lifetime) _____

Physician's Name: _____ NPI # _____

Physician's signature: _____ Date: _____