



HEAVYWEIGHT WHEELCHAIR (WEIGHT 300 LBS OR MORE)
WRITTEN ORDER PRIOR TO DELIVERY

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Patient Name: Patient DOB:
Patient Address: City: SS#/HICN:
State: Zip Code: Patient Telephone:
Height: Weight: Seated Hip Measurement: Diagnosis:

ORDER DATE: (ICD-10 CODES):
Date Patient Last Seen: Discharge Date: Prognosis:

HEAVY DUTY MANUAL WHEELCHAIR (WEIGHT 300 LBS OR MORE) (K0007, QTY: 1) | WITH: ANTI-TIPPING DEVICE (E0971, QTY: 2) HEEL LOOP (E0951, QTY: 2) AND BRAKE HANDLE EXTENSIONS (E0961 QTY:2)

Medical records documenting a face to face evaluation that the item is "reasonable and necessary" using the following criteria must be attached

- 1. Patient has a mobility limitation that significantly impairs his/her ability to participate in 1 or more mobility related activities
2. Patient's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker
3. Patient's home provides adequate access between rooms, maneuvering space, surfaces for use of the manual wheelchair
4. Use of a manual wheelchair will significantly improve the patient's ability to participate in MRADLs and will be used on a regular basis in the home
5. Patient has not expressed an unwillingness to use the manual wheelchair that is provided in the home
6. Patient has sufficient upper extremity function, physical, mental capabilities needed to safely self-propel the manual wheelchair OR
7. Patient has a caregiver who is available, willing, and able to provide assistance with the wheelchair
8. Patient weighs more than 300 Lbs.

Optional Accessories:

- 1. ADJUSTABLE HEIGHT ARMS are necessary because the patient requires an arm height that is different than that available using nonadjustable arms and spends at least two hours per day in a wheelchair (E0973, QTY: 2)
2. SEAT BELT-The Patient has weak upper body muscles, upper body instability or muscle spasticity which requires use of a safety belt/pelvic strap for proper positioning (E0978 QTY 1)

If patient's hip measurement exceeds 19" across, please provide a NON-STANDARD SEAT FRAME WIDTH (22"OR 24" WIDTH) (E2202, QTY: 1)

BACK SUPPORT CUSHION - General Use (E2612, QTY: 1)

SEAT CUSHION - E2602 General Use, E2604 Skin Protection, E2608 Skin Protection and Positioning QTY: 1

CUSHION SELECTION IS BASED ON THE QUALIFYING DIAGNOSIS BELOW (SEE ICD-10 DIAGNOSIS CODES ON BACK)

COMPLETE THE DIAGNOSIS CODES BELOW

G20. Parkinson's G35. Multiple Sclerosis G81. Hemiplegia G82. Paraplegia
G30. Alzheimer's G71. Muscular Dystrophy G82. Quadriplegia L89. Pressure Ulcer
Other: IF NO DIAGNOSIS CODE IS PROVIDED A E2601 GENERAL USE CUSHION WILL BE DELIVERED

WHEELCHAIR ELEVATING LEG REST / ARTICULATING LEG REST (K0195/K0053) Indicate which of the following conditions describe the patient (CHECK ) all that apply

- 1. Patient has a musculoskeletal condition or the presence of a cast or brace which prevents 90 degree flexion at the knee
2. Patient has significant edema of the lower extremities that requires having an elevating leg rest
3. Patient meets the criteria for and has a reclining back on the wheelchair

I, the undersigned, certify that the above prescribed equipment/supplies is medically necessary as part of my treatment for this patient. In my opinion, the equipment prescribed is reasonable and necessary for accepted standards of medical practice and treatment of this patient's condition and has not been prescribed as "convenience equipment".

Physician Name: Physician Telephone #:
Physician Address: City: State: Zip Code:
Physician Signature: NPI#: Date: