Detailed Written Order for Manual Mobility

Patient Name:_____ **DOB:** ____/____/_____ **Height** _____ **Weight** _____

Doctor Name: **NPI:**

Doctor Address: **Phone:**

1. **Start Date:** ____/____/_____ **Length of Need:** LIFETIME (99), unless otherwise specified (months) _____

2. **Diagnosis Codes (ICD_10)** _____, _____, _____, _____, _____, _____,

I am prescribing the following item(s):

3.

Walkers:
- ❑ Standard, Pick-Up
  - ❑ Rigid (E0130)
  - ❑ Fold up (E0135)
- ❑ Wheeled
  - ❑ Rigid (E0141)
  - ❑ Fold Up (E0143)
- ❑ Heavy Duty
  - ❑ Wheeled (E0149)
  - ❑ No wheels (E0148)
  - ❑ Multiple braking system (E0147)

Accessories:
- ❑ Platform attachment (E0154)
- ❑ Wheel attachment for rigid walker (E0155)
- ❑ Seat attachment (E0156)
- ❑ Leg extensions, set (E0158)

Canes:
- ❑ Single point (E0100)
- ❑ Quad or three-pronged (E0105)

Lifts:
- ❑ Pt Lift **-** Hydraulic or mechanical (E0630) (Includes any seat, sling, straps, or pads)
- ❑ Pt Lift **–** Electric (E0635) (Includes seat or sling)

Manual Wheelchairs:
- ❑ Transport Chair (E1038)
- ❑ Transport Chair – Heavy duty (more than 300#) (E1039)
- ❑ Standard wheelchair (K0001)
- ❑ Standard hemi-wheelchair (K0002)
- ❑ Lightweight wheelchair (K0003)
- ❑ High strength lightweight wheelchair (K0004)
- ❑ Ultralightweight wheelchair (K0005)
- ❑ Heavy duty wheelchair (more than 250# or severe spasticity) (K0006)
- ❑ Extra heavy duty wheelchair (more than 300#) (K0007)

Accessories:
- ❑ Adjustable height armrests (E0973) (❑ qty 1, qty ❑ 2)
- ❑ Elevating leg rests (E0990/K0195) (❑ qty 1, qty ❑ 2)
- ❑ Anti-tippers (E0971)
- ❑ Seatbelt (E0978)
- ❑ Wheel lock brake extension (E0961)
- ❑ General use seat cushion (E2601, E2602)
- ❑ General use back cushion (E2611, E2612)
- ❑ Non-standard seat frame (20-24") (E2201)
- ❑ Non-standard seat frame (24-27") (E2202)
- ❑ Manual fully reclining back (E1226)
- ❑ Other, please specify:_____

Other items that I am prescribing

_____

_____

4. I state that: **(a)** I am treating this patient on the effective date of this order, **(b)** This order accurately reflects this patient's diagnosis and condition and is substantiated by my medical records. **(c)** I have seen this patient within the last 6 months. **(d)** I will make the original signed copy of this document a part of this patient's medical records and make it available to Medicare, Medicaid, and other insurers, or any authorized agent, if requested.

SIGNATURE: _____ **DATE:** _____/_____/_____