CONDITION STATEMENT FOR MANUAL WHEELCHAIR

CLIENT'S NAME: _____ CLIENT'S HICN: _____

DATE OF BIRTH: _____ HEIGHT: _____ WEIGHT: _____

ADDRESS: _____

TELEPHONE: _____

EXAMINATION DATE: _____

DIAGNOSES CODES AND CONDITIONS THAT SUPPORT THE CLAIM FOR WHEELCHAIR:

_____

_____

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TYPE OF ACCESSORIES REQUIRED:

Circle One: Oxygen Holder Elevating Leg Rest Other: _____

EXPECTED LENGTH OF TIME PATIENT WILL REQUIRE WHEELCHAIR:

Months Needed _____ (99 = Lifetime)

DR. _____

_____

_____

PHYSICIAN OR TREATING PRACTITIONER'S SIGNATURE: _____

DATE SIGNED: _____ UPIN: _____ NPI: _____