PROGRESSIVE HOME MEDICAL Setting the Standard

Fax 480.895.2949

Phone 480.802 0202

Referred by_____

******Valley Wide Service******

Patient's Name: _____Date of Birth: _____

Address: _____City: _____ Zip:_____

Patient's Phone: (Home) _____ (Cell) _____ (Work) _____

******Please Send a Copy of All Insurance Cards With This Form******

Height_____ Weight_____ Width of Wheelchair_____

❒ Standard Manual Wheelchair (K0001) Upto 249lb & over 5'4"

❒ Heavy Duty Wheelchair (K0006) 250-299lbs

❒ Standard Hemi (low seat) Wheelchair (K0002) Upto 249lb & 5'4" & under

❒ Extra Heavy Duty Wheelchair (K0007) Over 300-lbs

❒ Seat Cushion (E2601) ❒ Back Cushion (E2611) ❒ Heel Loops (2) (E0951)

❒ Anti Tippers (2) (E0971) *Required for safety to prevent wheelchair from tipping backward resulting in user injury.*

❒ Seat Belts (E0978) *Covered if the patient has weak upper body muscles, upper body instability or muscle spasticity which requires use of this item from proper positioning*

❒ Wheel lock extension extensions(2) (E0961) *Allows wheelchair user to independently operate wheel locks due to upper extremity weakness, decreased range of motion, spasticity, or hemiplegia.*

❒ Elevating Leg Rests (E0990) *Covered if the patient has a musco-skeletal condition or the presence of a cast or brace which prevents 90 degree flexion at the knee; or the patient has significant edema of the lower extremities that requires an elevating legrest; or the patient meets the criteria for and has a reclining back on the wheelchair*

❒ Folding Front Wheel Walker (E0143) ❒ Seat Attachment

ICD10 Diagnosis Code:

_____ _____ _____ _____

_____ _____

PHYSICIAN'S ADDRESS STAMP AND PHONE NUMBER

Length of Need: [X] Lifetime _____

I certify that I am the treating physician identified on this form. Any statement on my letterhead attached hereto, has been reviewed, and signed by me. I certify that the medical necessity on this form is true, accurate, and complete, to the best of my knowledge.

PHYSICIAN'S SIGNATURE: _____DATE: ____/_____/_____

Print Physician's Name _____ NPI _____