



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

☐ Lightweight Wheelchair (K0003)

☐ Reclining Back for wheelchair (E1226)

☐ 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 (K0195) *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: ☒ 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: _____ Signature /Start Date: ____/____/____

Print Physician's Name _____ NPI _____