Home Medical Supplies, Inc.

8600 Park Meadows Dr. Suite 50 Lone Tree, CO 80124-2756

Physician order for K5 Manual Wheelchair

Local Phone: 303-751-3700 * Local Fax: 303-745-3101 * Email: hmsinc@live.com

Patient Name: _____ DOB: _____ Phone: _____ HT_____ WT____

Address: _____ City: _____ State: _____ Zip: _____

Medicare#:_____ Medicaid#:_____

Secondary INS: _____ Policy#_____ Group#_____

Address: _____City: _____ State: _____ Zip: _____ Phone: _____

☑ **Item Ordered: K0005 Manual Wheelchair 16",18",20",22" Ultra-Light Weight**
☐ **ELR Leg Rests** ☐ **Anti Tip Bars** ☐ **Removable Arm Rests** ☐ **Seat Belt**
☐ **Air Chambered Seat Cushion** ☐ **Gel Seat Cushion** ☐ **Back Seat Cushion**

The above equipment is needed by this patient. Length of Need: [____] Months [____] Lifetime

☑ **ICD-9 Codes: Please check all that apply**

☐ **V43.65** –Replacement knee joint total
☐ **715.16** - Osteoarthrosis, localized, primary; lower leg, Fibula, Knee joint, Patella, Tibia
☐ **722.4** _____
☐ **Prognosis:** ☐ **Excellent** ☐ **Good** ☐ **Fair** ☐ **Poor** ☐ **Uncertain** _____

☐ Yes ☐ No 1. Does the patient have a mobility limitation which impairs daily living activities?
☐ Yes ☐ No 2. Can the mobility deficit be resolved using a cane, crutches or a walker?
☐ Yes ☐ No 3. Is the patient able to safely operate a manual wheelchair?
☐ Yes ☐ No 4. Does the patient have a need to place his/her feet on the ground to self-propel?
☐ Yes ☐ No 5. Can the patient safely propel a standard weight wheelchair (36lbs or more) using arms and or feet?
☐ Yes ☐ No 6. Does the patient require a skin protection cushion rather than a general use cushion in the manual wheelchair? General use E2601
☐ Yes ☐ No 7. If yes, does the patient suffer from skin breakdown? If yes, Where? _____ ☐ Gel Skin Protection E2603 ☐ Lumbar Support E2611
☐ Yes ☐ No 8. Does the patient's medical record reflect the need for a wheelchair?

I, the undersigned, certify that the above prescribed durable medical equipment 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 Signature:** _____ Date: _____

Physician Name Printed: _____ NPI#_____

Address: _____City:_____State:_____Zip:_____

Phone: _____ Fax: _____ Email: _____

Assignment of Benefits

I request that the payment of Medicare/insurance benefits be made on my behalf to the supplier for the equipment, supplies & or services provided to me by the supplier. I authorize the release of medical information to Home Medical Supplies, Inc. This authorization will remain in effect until written notification by my legal representative or me.

✍ **Patient/Legal Representative:** _____ **Date:** _____

✍ **HMS, Inc. Representative:** _____ **Date:** _____