MEDICAL PHARMACY
1213 MAIN STREET
WILLIMANTIC, CT. 06226
PH: (860) 423-1661
F: (860) 456-2944

MEDICAL PHARMACY
WWW.MEDICALPHARMACYCT.COM\

MEDICAL PHARMACY LTC
1197 MAIN STREET
WILLIMANTIC, CT. 06226
PH: (860) 423-1661
F: (860) 423-3861

CHAD WOJNAR R.PH., PRESIDENT
JACK LOVELAND R. PH., VICE PRESIDENT

Physician's Order Form for Extra Heavy Duty Wheelchair (K0007)

(Over 300lbs) ☐ With Cushion ☐ With Elevating Leg Rests

Date Ordered: ___/___/_____ ☐ Initial ☐ Renewal **Date of Face to Face:** ___/___/_____

Patient's Name: _____ **DOB:** _____/_____/_____

Patient's Address: _____

_____

Insurance ID #: _____ **Height:** ____'____" **Weight:** _____lbs

The physician must complete this information in order to comply with Medicare Guidelines

Diagnosis/ICD-10 Code:_____ **Length of Need:** _____

****Please answer all of the following questions****

1. Does the patient have a mobility limitation that significantly impairs his/her ability to participate in one or more mobility related activities of daily living (MRADL) in the home. ☐ Yes ☐ No
2. Can the mobility deficit be sufficiently resolved by using a cane, crutches, or a walker? ☐ Yes ☐ No
3. Is the patient able to safely use the manual wheelchair? ☐ Yes ☐ No
4. Can the functional mobility deficit be sufficiently resolved by use of a manual wheelchair? ☐ Yes ☐ No
5. Does the patient weigh more than 300 pounds? ☐ Yes ☐ No

Physician Name:_____ **NPI #** _____

Physician's Address:_____

I, the undersigned, certify the above prescribed equipment and/or supplies are medically necessary as part of my treatment for this patient. In my opinion, the equipment and/or supplies prescribed are both reasonable and necessary for accepted standards of medical practice and treatment of this patient's condition. Neither the equipment and/or supplies are being prescribed as "convenience equipment".

Physician's Signature :_____**Date** ____/____/_____

LC