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

Physician's Order Form for Transport Chair (E1038)

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 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 mobility be sufficiently resolved by using a cane, crutches, or a walker? ☐ Yes ☐ No
3. Does the patient's home provide adequate access between rooms, maneuvering space, and surfaces for use of a transport chair? ☐ Yes ☐ No
4. Will the use of the transport chair significantly improve the patient's ability to participate in regular MRADL? ☐ Yes ☐ No
5. Is the patient willing and able to safely use the transport chair in the home?... or… ☐ Yes ☐ No
6. Does the patient have a caregiver who is available, willing, and able to provide assistance with a transport chair? ☐ 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 ____/____/_____

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