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 Heavy Duty Wheelchair (K0006)

(Over 250lbs) ☐ 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 250 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