## **Everything Medical**

##### 530-223-3633 / Fax: 530-223-3636

###### PRESCRIPTION FOR POWER MOBILITY ASSISTIVE EQUIPMENT

# Physician Information:

|  |  |
| --- | --- |
| Name: |  |
| Mailing Address:  |  |
| City: |  | State: | **CA** | Zip: |  |  |
| Telephone: |  |  | NPI:  |  |

# Patient Information:

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:**  |  | **HICN#:** |  |
| **Mailing Address:** |  | **Phone:** |  |
| **City:**  |  | **State** **Ht:**  | **CA** | **Zip:** |  |
| **DOB:** |  |  |  **Wt:** |  | **Lbs.** |  |
|  |  |  |  |  |  |

Numeric ICD-9 Diagnosis codes that necessitate this patient’s need for

MAE: \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

Date of Power Mobility Face-To-Face examination: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Length of Need: \_\_\_\_\_\_\_\_\_ months (99= Lifetime)

 Items ordered include the following:

 **(1) Power Wheelchair**

 **(2) Batteries (E2361, E2363, E2365 based on equipment ordered)**

 **(1) Heavy Duty Package (K0108)**

 **(2) Elevated Leg-rest (E0990)**

 **(2) Calf Pads for Elevated leg-Rest**

 **(1) Oxygen Tank Holder (E2208)**

 **(1) Special Seat Depth (K0108)**

 **(1) Special Seat Width (K0108)**

 **(2) Adjustable height Armrests (E0973)**

 **(1) Seat / Back Cushion (K0108), (code based on equipment ordered)**

 If any of these items are unnecessary, please line through them.

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#### Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_

#### License #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NPI#\_\_\_\_\_\_\_\_\_\_\_\_\_\_**