## **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.

----------------------------------------------------------------------------------------

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

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

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