inter phase
Partners In Healthcare

Wheel Chair Prescription Form

Phone: 215-743-1100 & 800-344-1550 Fax: 215-743-0105

Patient Information ******Please Attach Face Sheet w/ Patient Demographics & Insurance Information******

Patient Name_____ Date of Birth_____

*Preferred Language*_____ Patient Cannot Accept Deliveries on the following days (circle) *Mon Tues Wed Thu Fri Sat*

Height:_____ Weight:_____

Primary Diagnosis	***Secondary Diagnosis***
*ICD-10 Code:*_____	*ICD-10 Code:*_____
***Non-Specified Codes will not qualify for Primary Diagnosis.*	

Equipment Ordered

[ ]_____

Size of Chair_____

Does this equipment require any add-ons?_____

Please see the questions below in regards to the equipment prescribed for this patient & Circle One

- ***Is the patient able to ambulate?*** ***Yes or No***
  - ***If yes, how far?*** ***Yes or No***
- ***Is patient able to ambulate up stairs?*** ***Yes or No***
- ***Is the patient able to ambulate with the use of a cane or walker?*** ***Yes or No***
- ***Is the patient/caregiver able to propel wheelchair?*** ***Yes or No***
- ***Would the patient be confined to bed or chair without equipment?*** ***Yes or No***
- ***Does patient need wheelchair to navigate their residence?*** ***Yes or No***

Order Date_____/_____/_____ ***Start Date _____/_____/_____*** ***Length of Need_____ Months***

I certify that the above products are medically necessary and that the information provided is accurate to the best of my knowledge. By signing below, I acknowledge that I have obtained the patient's authorization to release the above information and other medical information that maybe disclosed. I certify that my decision to prescribe this recommended product was based solely based on my determination of medical necessity set forth herein.

Facility Name_____ Contact Person_____ Fax/Email_____

Phone Number_____ Address _____

Ordering Physician (Please Print)_____ NPI #_____ License #_____

Physician Signature_____ **Date** _____/_____/_____ Pecos Certified *(circle one) Yes No*