AUBURN PHARMACY

Detailed Physician Order

Wheel Chair

Patient Name: _____ Insurance #: _____

Address: _____ Phone: _____

_____DOB: _____

Date of Order_____/_____/_____ Est. Length of Need in Mos. (99 = Life)_____
Diagnosis (List All) (1) _____(2) _____ (3) _____(4) _____
Prognosis (Good, Fair, Poor): _____ Height: _____Weight: _____

Type of Equipment: **Manual Wheelchair**
K0001: Standard; **K0003:** Lightweight; **K0006:** Heavy Duty >250# **K0007:** Extra Heavy Duty<300#
E1038: Transport Chair≤300#; Transport Chair >300#
WC Accessories: E2208: O2 tank carrier; **E0971:** Anti-tipping; **E0990:** Elevating leg rest
MODIFERS: **KX** met all criteria, **RR** rental, **KH** 1st month, **KI** 2 + 3 month & **KJ** 4-13 month

1. Does the patient have a mobility limitation that impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADLs—toileting, feeding, dressing, grooming, and bathing) in customary locations of the home? □ **YES** □ **NO**

2. Can the patient's mobility limitation be resolved with the use of a fitted cane or walker? □**YES** □**NO**

3. Does the patient's home provide adequate access between rooms, maneuvering space and surfaces for use with a manual wheelchair? □**YES** □ **NO**

4. Will use of a manual wheelchair significantly improve the patient's ability to participate in MRADLs and the patient will use it on a regular basis in the home? □**YES** □**NO**

5. The patient is willing to use a manual wheelchair in the home? □**YES** □**NO**

6. Does the patient have sufficient upper extremity function and other physical and mental capabilities needed to safely self propel the manual wheelchair in the home during a typical day? □ **YES** □ **NO**

7. Does the patient have enough upper body strength to use this wheelchair?
□**YES** □ **NO**

If Question 7 is NO, then Question 8 must be YES for coverage

8. Does the patient have a caregiver who is available, willing, and able to provide assistance with the wheelchair? □**YES** □**NO**

Provider: AuBurn Pharmacy Inc. Physician: _____

Address: _____ Address: _____

_____ _____

Phone: _____ Phone: _____

NPI #: _____ NPI#: _____

Physician Signature: _____ Date: _____/_____/_____