PRISM HEALTH CARE SERVICES, INC.
MEDICAL SUPPLIES • RESPIRATORY EQUIPMENT

Written Order Prior to Delivery (WOPD)
Wheelchair

Prism Health Care Services, Inc.
1337 Basswood Road
Schaumburg, IL 60173-4536
Phone: 847-310-4730 *3
Fax: 872-469-1673

Order Date: _____

Patient Name: _____ Home Phone: _____

Date of Birth: _____ Cell Phone: _____

Diagnosis: 1 _____ 2 _____ 3 _____

Mobility Device (select one and indicate size or type if applicable)

Wheelchair Standard (K0001)	☐	**Patient weighs 250 lbs. or less**
Wheelchair-Hemi (K0002)	☐	**Patient weighs 250 lbs. or less and requires a lower seat height.**
Wheelchair-Lightweight (K0003)	☐	**Notes must indicate patient tried, but cannot self propel a standard w/c, but can self-propel a lightweight wheelchair**
Wheelchair-Hi Strength Ltwt. (K0004)	☐	**Please contact office to verify criteria before completing this form.**
Wheelchair-Heavy Duty (K0006)	☐	**Patient weighs more than 250 lbs. up to 300 lbs.**
Wheelchair-Extra Heavy Duty (K0007)	☐	**Patient weighs more than 300 lbs.**
Non-Standard Seat E2201)	☐	**Requiring a seat width or depth of 20 inches or more.**
Reclining Back (E1226)	☐	**High Risk for pressure ulcer and is unable to weight shift or required for bladder management.**
Standard Footrests (E1399)	☐	**Non-elevating, flip up - (standard if elevating leg rests are not ordered).**
Elevating Leg Rests - pair (K0195)	☐	**Patient has edema or condition that prevents 90 degree flexion of knee.**
Articulating Leg Rests - each (K0053)	☐	**Patient has edema or condition that prevents 90 degree flexion of knee. Adjustable leg rest-commonly used for taller person.**
Anti Tippers (E0971)	☐	**Stabilizes the wheelchair and prevents tipping.**
Transport Chair (E1038)	☐	**Must meet qualitifications for a wheelchair, Patient weighs 300 lbs. or less**
Transport Chair (E1039)	☐	**Must meet qualitifications for a wheelchair, Patient weighs more than 300 lbs.**
WC Back Cushion General Use (E2611)	☐	**Must meet qualitifications for a wheelchair, seat width < 22 inches**
WC Seat Cushion General Use (E2601)	☐	**Must meet qualitifications for a wheelchair, seat width < 22 inches**
Pelvic Obliquity Kit - POK	☐	**Inserted into cushion, allows adjustment of seat angle, indicate side needed: Left or Right**

PLEASE SUBMIT THIS FORM ALONG WITH A FACE TO FACE, AND CLINICAL NOTES, i.e. doctors, progress, nurses, occupational therapy, and physical therapy notes. The notes must include diagnosis and the need for the equipment. Also, it is required that the date of this form is the same or after the date on the Clinical Notes and Face to Face.

The following criteria must be met for the above selected item to be covered,
(this information has been obtained from the Medicare Policy)

* The beneficiary has a mobility limitation that significantly impairs his/her ability to participate in one or more MRADL in the home.

A mobility limitation is one that:

1. Prevents the beneficiary from accomplishing the MRADL entirely, OR
2. Places the beneficiary at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform the MRADL, OR
3. Prevents the beneficiary from completing the MRADL within a reasonable time frame

AND

* *The beneficiary mobility limitation cannot be sufficiently resolved by the use of a cane or walker.*
* *The beneficiary's home provides adequate space to maneuver the wheelchair, and the beneficiary or caregiver is able and willing to use the wheelchair.*

If the criteria are not met, or proper documentation is not received the wheelchair will be denied as not medically necessary. If the wheelchair is needed for outdoor activities only, it will be denied as not medically necessary.

Physician Name: _____ **NPI:** _____

Physician Signature: _____ **Date :** _____

Physician Phone: _____ **Fax:** _____

I certify that I am the treating physician identified on this form. Any statement on my letterhead attached here to, has been reviewed and signed by me. I certify that the medical necessity information on this form is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.