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

Wheelchair
Standard Written Order (SWO)

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 _____

PLEASE SUBMIT THIS FORM ALONG WITH A FACE TO FACE, AND CLINICAL NOTES, i.e. doctors, progress, nurses, occupational therapy, and/or 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. All notes and documentation must be received prior to delivery.

A, B, C, D, E and F or G, must be met to qualify for a standard wheelchair. All other wheelchairs, see the criteria inder Mobility Devices.

A The beneficiary has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADLs) such as toileting, feeding, dressing, grooming, and bathing in customary locations 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

B The beneficiary mobility limitation cannot be sufficiently resolved by the use of a cane or walker. **AND**

C The beneficiary's home provides adequate space to maneuver the wheelchair, and the beneficiary or caregiver is able and willing to use the wheelchair. **AND**

D Use of a manual wheelchair will significantly improve the beneficiary's ability to participate in MRADLs and the beneficiary will use it on a regular basis in the home. **AND**

E The beneficiary has not expressed an unwillingness to use the manual wheelchair that is provided in the home. **AND**

F The beneficiary has sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the manual wheelchair that is provided in the home during a typical day. Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function. **OR**

G The beneficiary has a caregiver who is available, willing, and able to provide assistance with the wheelchair.

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)	☐ **Patient can complete activities using this wc, but cannot completeADL's using a standard or lightweight wheelchair, OR, Patient requires requires a seat width, depth, or height that cannot be accommodated in a standard, lightweight or hemi-wheelchair, and spends at least two hours per day in the wheelchair.**
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**

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.