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WHEELCHAIR ORDER FORM

****Please attach face sheet w/ patient demographics & insurance info****

PATIENT INFORMATION

Patient Name: _____ DOB: ____/____/____ Gender: Male Female
Language Pref.: English Spanish Other: _____ Patient cannot accept deliveries on the following days?
Height: _____ Weight: _____ Mon Tues Wed Thurs Fri Sat

DIAGNOSIS

Primary Diagnosis ICD-10 Code: _____ <small>*Non-Specified Codes will not qualify for Primary Diagnosis</small>	Secondary Diagnosis ICD-10 Code: _____
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EQUIPMENT:

Type of chair: _____
Size of chair: _____
Does this patient require any add-ons? Yes No
If yes, what kinds?: _____

Please answer questions below in regards to the equipment ordered for this patient.

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

Order Date: ____/____/____ Length of Need: _____ months

REFERRAL INFORMATION

Ref #: _____

Practice Name: _____ Fax: _____
Office Address: _____ Email: _____
Phone: _____ Preferred Method of Contact? Phone Fax Email
Contact Person: _____

Physician Name: _____ NPI#: _____ Phone: (____)____-____ Ext. _____
Physician Signature: _____ Date: ____/____/____

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 may be disclosed. I certify that my decision to prescribe this recommended product was solely based on my determination of medical necessity set forth herein. This document may serve as a confirmation of a verbal order and is also recorded in the patient's record.

Assignment of Benefits: I request that payment of my insurance benefits be made to CHC Solutions, Inc., or any of its subsidiaries, for any supplies or services they provide me. I am responsible for any balance due that is not covered by my insurance. I understand any product received in my home cannot be returned if opened. By signing below, I authorize the distribution of my information to CHC Solutions, Inc., or any of its subsidiaries, which may be needed to determine benefits payable for these services or supplies. I authorize CHC Solutions, Inc., or any of its subsidiaries, to forward my medical records to the medical professionals in my care and/or make copies of said records.

Patient Signature: _____ Date: ____/____/____