

Wheelchair Order Form

North Shore Home Medical Supply

To Whom it may concern:

104 Newbury St.
Peabody, MA 01960

Please review the following documents and fill out accordingly. In order for us to bill your patient's insurance, these documents are required. Please include all pertinent patient information such as:

Phone number: 978-535-3893
Fax number: 617-497-4021

- Patient name
- Date of Birth
- Address
- Insurance information (including secondary insurance if applicable)
- Contact information
- Emergency contact information if necessary
- Diagnosis
- Patient height/weight

If you have any questions, do not hesitate to call us at 978-535-3893. Please fax completed documents to **617-497-4021**.

Thank you.

North Shore Home Medical Supply Staff

All orders for insurance will be processed through our subsidiary Ciampa Apothecary.

Wheelchair Order Form

Prescriber Information

Prescriber Name:	
Address:	
Phone Number:	
Fax Number:	
NPI	

Patient Information

*You may also attach face sheet if it contains the following information

Patient Name:	Date of Birth:
Address:	Height:
	Weight:
Phone Number:	Emergency Contact:
Primary Insurance/ID#	Secondary Insurance/ID#
Diagnosis:	Length of Need:

Additional Information:	
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Wheelchair Ordered: (please circle one)

	Lightweight	Heavy-Duty	
Standard	Initial if Pt is unable to self propel in standard weight chair: _____	Initial if Pt weighs more than 350 lbs _____	Quantity: _____

By signing below, I certify that one of the following statements are true:

- Patient has a mobility limitation that significantly impairs his/her ability to participate in one or more-related activities of daily living (MRADL).
- The patient's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker.
- The patient's home provides adequate access between rooms, maneuvering space and surfaces for use of the manual wheelchair that is provided.
- Use of a manual wheelchair will significantly improve the patients ability to participate in MRADLs and the patient will use it on a regular basis in the home.
- The patient is willing to use it around the home.
- The patient has sufficient upper body strength and other mental and physical capabilities to self propel the wheelchair around the home.

Prescriber Signature:	Date:
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Wheelchair Seating Order Form

Prescriber Information

Prescriber Name:	
Address:	
Phone Number:	
Fax Number:	
NPI	

Patient Information

*You may also attach face sheet if it contains the following information

Patient Name:	Date of Birth:
Address:	Height:
	Weight:
Phone Number:	Emergency Contact:
Primary Insurance/ID#	Secondary Insurance/ID#
Diagnosis:	Length of Need:
Additional Information:	

Wheelchair Ordered: (please circle one)

Please Select on of the following options:

Standard/General use Seat Cushion _____

Or

Standard/General use Back Cushion _____

Requirements

The Patient currently has a manual wheelchair which meets all guidelines of approval based on Medicare guidelines

Skin Protection Seat Cushion (Gel Cushion)

Requirements (Please circle all that apply)

- Patient has a current pressure ulcer or past history of pressure ulcer on the area of contact with the seating surface
- Patient has absent or impaired sensation in the area of contact with seating surface or inability to carry out a functional weight shift due to a medical diagnosis above

Initial if the patient meets requirements for Skin Protection Cushion: _____

Prescriber Signature:	Date:
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