L11443 Manual Wheelchair

PROVIDER:	ALLSTATE DME LLC		**PATIENT:**	PATIENT, TEST	
	4009 S. SUGAR RD.				
	EDINBURG, TX 78539			TX	
	Phone	(956) 287-8585		**Phone**	
	FAX	(956) 287-8586		**DOB**	01/01/1900
	Provider No.	6385310001		**Initial Date**	
PHYSICIAN:				**Revised Date**	
				Recertification	
				Length of Need (in months)	
	UPIN	**NPI**			
	Phone	**Fax**		**Policy**	

DIAGNOSIS

ICD-9 Code	Description

EQUIPMENT/SERVICES

Qty	Proc. Code	Item Name/Narrative
1	K0001	WHEELCHAIR FIX ARM WITH FOOTREST

ADDITIONAL MEDICAL INFORMATION

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) such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home?
Can the patient's mobility limitation be sufficiently resolved by the use of an appropriately fitted cane or walker? Y / N
Does the patient's home provide adequate access between rooms, maneuvering space, and surfaces for use of the manual wheelchair that is provided? Y / N
Will the use of a manual wheelchair improve the patient's ability to participate in MRADLs and the patient will use it on a regular basis in the home? Y / N
Has the patient expressed a willingness to use the manual wheelchair that is provided in the home? Y / N
Does the patient have 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? Y / N
Does the patient have a caregiver who is available, willing, and able to provide assistance with the wheelchair? Y / N
How much does the patient weigh? ________ lbs

Clinician Signature ______________________________ **Date** ____________

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L11443 Manual Wheelchair - Manual Wheelchair Bases (L11443), K001, K0002, K0003, K0004, K0006, or K0007

Date: 9/12/2010
Patient: PATIENT, TEST

HICN:

,
Phone:
Fax:

Equipment/Services:
K0001 WHEELCHAIR FIX ARM WITH FOOTREST

Dear Physician,
The following information was provided to our office as part of the order intake process. Please confirm that the information is correct. If the information is correct it needs to be inserted into the attached Written Order form. Any changes or corrections should also be inserted into the attached form. Once all sections of the Written Order are completed, please sign, date and mail the form back to our office.
Thank you.

Questions Reviewed:	Answers:
Diagnosis of Patient?	
Estimated Length of Need? 1-99 (99=Lifetime)	
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How much does the patient weigh? ________ lbs	