FOR POWERED MOBILITY ITEMS

WHAT NEEDS TO BE INCLUDED IN PRESCRIPTION

1. BENEFICIARY NAME
2. DESCRIPTION OF ITEM TO BE ORDERED, INCLUDE WEIGHT AND HEIGHT
3. DATE OF FACE TO FACE EXAMINATION
4. DIAGNOSIS/ CONDITION
5. LENGTH OF NEED
6. PHYSICIAN SIGNATURE
7. DATE OF PHYSICIANS SIGNATURE

Prescription

FACE TO FACE EVALUATION

1. HISTORY OF PRESENT CONDITION AND RELEVANT PAST MEDICAL HISTORY
2. SYMPTONS THAT LIMIT AMBULATION
3. DIAGNOSES THAT ARE RESPONSIBLE FOR THE SYMPTONS
4. MEDICATIONS OR TREATMENTS FOR SYMPTONS AND CONDITIONS
5. PROGRESSION OF AMBULATION DIFFICULTY OVER TIME
6. OTHER DIAGNOSIS THAT MAY RELATE TO AMBULATORY PROBLEMS
7. DISTANCE BENEFICIARY CAN WALK WITHOUT STOPPING
8. PACE OF AMBULATION
9. HISTORY OF FALLS INCLUDING FREQUENCY AND CIRCUMSTANCES LEADING TO FALLS
10. WHAT AMBULATORY ASSISTANCE (SUCH AS WALKER, CANE, WHEELCHAIR) IS THE PATIENT USING AND WHY ISN'T IT SUFFICIENT
11. WHAT HAS CHANGED IN ORDER FOR THE PATIENT TO NEED A POWERED MOBILITY ITEM NOW
12. HEIGHT/ WEIGHT

13. Clinical Notes

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Professionalism,Excellence&Reliability

POWER MOBILITY DETAILED ORDER &PRODUCT DESCRIPTION

Patient_____ **Physician** _____
DOB_____ **TEL**_____**FAX**_____
Address_____
_____
_

1. **Diagnosis** ----------**Code**----------
2. **Diagnosis**----------**Code**----------
3. **Diagnosis**----------**Code**----------
4. **Diagnosis**----------**Code**----------

HCPC	Description	QTY	CHG	Allowable

Additional Items----------

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By Signing below I certify and agree that the above prescribed power mobility device and accessories are medically necessary for the patient to perform mobility related activities of daily living. I hereby incorporate this document into my patient medical records .

Physician's Signature----------

Date----------

7-Element Written Order

Beneficiary's Name

_____

Description of the item ordered

_____

Date of the face-to-face examination

(Date the face-to-face process is complete)

_____

Pertinent diagnoses/conditions that relate to the need for the item ordered

_____

Length of need

_____

Physician signature

_____

Physician Name (Print Clearly)

_____

Date of physician signature

_____