FOR POWERED MOBILITY ITEMS

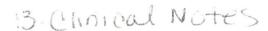
WHAT NEEDS TO BE INCLUDED IN PRESCRIPTION

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



FACE TO FACE EVALUATION

- 1. HISTORY OF PRESENT CONDITION AND RELEVANT PAST MEDICAL HISTORY
- 2. SYMPTONS THAT LIMIT AMBULATION
- 3. DIAGNOSIS 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



Delight Medicals,Inc

41 lebanon st Malden.ma 02148 Tel- 781-435- 0570

Fax:781-435-1390

Professionalism, Excellence & Reliability

POWER MOBILITY DETAILED ORDER &PRODUCT DESCRIPTION

Patient		PhysicianFAX			
DOB		TEL	FAX		
Address				1	
-					
1. Diag	nosis	Code	2		
2. Diag	nosis	Cod	e		
3. Diag	nosis	Cod	e		
	nosis				
HCDC	D	0.777			
HCPC	Description	QTY	CHG	Allowable	
Additional Items					
_					
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 nee	d for the item ordered
Length of need	
Physician signature	
Physician Name (Print Clearly)	
Date of physician signature	