A TO Z MEDICAL EQUIPMENT & SUPPLIES

MEDICAL EQUIPMENT PRESCRIPTION

Please send completed form along with patient's face sheet.

PHONE: (214) 349 - 2869 | FAX: (214) 349 - 2871

☐ Revised **EMAIL: ORDERS@ATOZWHEELCHAIRS.COM**

REFERRAL INFORMATION

Facility _____ Patient _____ Height _____

Facility Contact _____ * DX ICD-10 _____ Weight _____

Order Confirmation: Text / Email _____ Discharge Date _____ **Sex** _____

Delivery Contact Cell Number _____ Patient DOB: ____ Address: _____

Primary Insurance: _____ ID # _____ Secondary Insurance: _____ ID# _____

MANUAL WHEELCHAIRS

- ☐ Lightweight (K0003)
- ☐ Standard (K0001)
- ☐ Heavy Duty *(251+ Lbs.)*
- ☐ Extra Heavy Duty *(301+ Lbs)*
- ☐ *High Back Recliner*
- ☐ *Transport Chair*

- ☐ Elevating Leg Rests
- ☐ Height Adjustable Arms
- ☐ Brake Extenders
- ☐ Seat belt
- ☐ Rear Anti- Tippers

- ☐ Standard Foot Rests
- ☐ Oxygen Holder
- ☐ Swing Away Arm Trough: ☐Rt ☐Lt
- ☐ Amputee Rest: ☐ Rt ☐ Lt ☐ Aka ☐ Bka

Cushions:
- ☐ Cushions Seat / Back*
- ☐ Adjustable Skin Protection Cushion / Back**
- ☐ Roho Cushion / Back**

Seat Width: ☐16" ☐18"
Non Standard Width: ☐20" ☐22" ☐ 24" ☐26" ☐28" ☐ 30"
Seat Depth: ☐16" ☐18"
Hemi Height: ☐17"

* Check Box For Both or Circle One ** Patient must have at least history of a stage I sacral wound, Alzheimers, Parkinsons, Paralysis or Plegia to qualify.

POWER MOBILITY DEVICES

- ☐ **K0823 Standard Powerchair (Under 300 Lbs.)**
- ☐ **K0825 Heavy Duty Powerchair (301 Lbs. - 450 Lbs.)**
- ☐ **K0827 Extra Heavy Duty Powerchair *(451 Lbs. - 600 Lbs.)***
- ☐ **K0829 Extra Heavy Duty Powerchair *(+600 Lbs.)***
- ☐ ***K0800 Standard Power Scooter (Under 300 Lbs.)***
- ☐ ***K0801 Heavy Duty Power Scooter (301 Lbs. - 450 Lbs.)***

- ☐ Pan Seat Option
- ☐ Oxygen Holder
- ☐ Swing Away Arm: ☐Rt ☐Lt
- ☐ Amputee Rest: ☐ Rt ☐ Lt ☐ Aka ☐ Bka

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- ☐ Cushions Seat / Back*
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HOSPITAL BEDS

- ☐ Semi Electric Hospital Bed ☐Half Rail ☐Full Rail
- ☐ Gel Overlay
- ☐ Bariatric Bed *(351+ lbs)*
- ☐ Patient Lift (Hoyer)
- ☐ Trapeze
- ☐ Over Bed Table *($99)*
- ☐ Bed Assist Rail *($80)*
- ☐ Alternating Pressure Pad
- ☐ Pressure Mattress Non Powered**
- ☐ Pressure Mattress Powered** *(low air loss)*

* Gel Overlay Qualification = Partial immobility accompanied by altered sensory perception, incontinence, or impaired nutritional or circulatory status. **Medicaid, BCBSTX, & Molina Primary Only**

** Documentation Required - Patient must have at least a healing stage III, IV, or V wound on the back, trunk, or pelvis area.

AMBULATORY

- ☐ Rolling Walker ☐ **Add Seat Attachment**
- ☐ Junior
- ☐ Tall *(extensions)*
- ☐ Bariatric *(301+ Lbs.)*
- ☐ Platform Attachment ☐Rt ☐Lt
- ☐ Hemi Walker
- ☐ Basket *($25)*
- ☐ Tray *($35)*
- ☐ Knee Walker (BCBS Only)
- ☐ Folding Walker ☐ *w/ Seat Attachment*
- ☐ Quad Cane, Narrow
- ☐ Quad Cane, Wide
- ☐ Ortho Grip Cane
- ☐ Single Point Cane
- ☐ Offset Handle Cane

ARTHRITIS & MUSCULO

- ☐ **Soft Cervical Collar**
- ☐ **Hard Cervical Collar**
- ☐ **Philadelphia Cervical Collar**
- ☐ **Rigid Back Brace**
- ☐ **Lumbo-Sacral Back Brace**
- ☐ **Joint Splints**
- ☐ **Wrist Brace** ☐Rt ☐Lt
- ☐ **Knee Brace** ☐Rt ☐Lt
- ☐ **Ankle Brace** ☐Rt ☐Lt

Physician Phone #: _____ **Physician Fax #** _____

Physician's Signature: _____ **Length of Need (1-99 Months)** _____

Physician Name: _____ **NPI** _____ **Date:** _____