WOPD-Written Order Prior To Delivery

Service Provider: A to Z Medical Equipment 15060 E Beltwood Parkway, Suite B, Addison, Texas 75001
Phone: (214) 349-2869 Fax: (214) 349-2871

Date Of Order:_____

Patient Name:_____	**D.O.B**_____	**Medicare HICN**:_____
Height:_____ **Weight**:_____		**Date Of EXAM:**_____

The physician must complete the Face to Face encounter in office visit notes.

☐ **ULTRA LIGHTWEIGHT MANUAL WHEELCHAIR - K0005**

☐ **K0195 – ELEVATING LEG RESTS**

☐ **E2622 – Skin Protection, Adjustable Seat Cushion (**Current pressure ulcer or past history of pressure ulcer on area of contact with seating; or a Neurological Condition, Myopathy, or Skeletal Deformation)

☐ **E2613 – General Back Cushion (**Neurological Condition, Myopathy, or Skeletal Deformation that causes postural asymmetries)

☐ **E0973 – Adjustable Height / Detachable Armrest X 2** (Requires frequent weight shifts w/aid of adj. height armrest while sitting at any table in home)

☐ **E0971 – Anti-Tipping Device X 2 & E0951 Heel Loop / Holder** (Elevation changes in the home such as door thresholds, sunken rooms ect. Require the need for anti-tipping devices and heel loops to keep patient secure within the w/c while self propelling through home environment)

☐ **The beneficiary has a mobility limitation that significantly impairs his/her ability to participate in one or more MRADLS in the home.**

☐ **The beneficiary's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker.**

☐ **The beneficiary'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 beneficiary's ability to participate in MRADLS and the beneficiary will use it on a regular basis in the home**

☐ **The beneficiary has not expressed an unwillingness to use the manual wheelchair that is provided in the home.**

☐ **The beneficiary has sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel in the manual wheelchair that is provided in the home during a typical day. Limitations of strength, endurance range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function**

☐ **The patient has a Neurological, Congenital Skeletal Deformity, or Myopathy.**

☐ **Patient cannot self-propel in a STANDARD , LIGHTWEIGHT, or HIGH STRENGTH wheelchair in the home and requires an ULTRA-LIGHTWEIGHT wheelchair .**

Estimated Length of Need: _____ Months (99 = lifetime)

DIAGNOSIS (ICD-10 CODES)

(1): _____ (2): _____ (3): _____ (4): _____

BY SIGNING BELOW, I AUTHORIZE the use of this document as a legal prescription and I certify that above prescribed equipment is medically necessary and reasonable, and is now being prescribed for convenience. I will maintain an original signed copy of this supporting documentation in my medical records and make it available to Medicare, their authorized agency or other insurer, if required.

TREATING PHYSICAN: _____ **NPI #**: _____

DOCTOR'S SIGNATURE: _____ **DATE SIGNED/START DATE**: _____

No stamp signature or typed date accepted per Medicare guidelines

A TO Z
MEDICAL EQUIPMENT