

Advanced Medical Supply
3322 N. Milwaukee Avenue, Chicago, IL 60641
Phone: (773) 205-6993 Fax: (773) 205-6994

DETAILED WRITTEN ORDER

| | | |
|---|---|--------------------|
| Patient's Name: | John Brown | |
| Address: | 19718 Terrace Ave Apt1E Lynwood, IL 60411 | |
| Phone: | (708) 970-1520 | |
| DOB: | 07/10/1975 | |
| Insurance Name and ID. | Medicare:8QC8RQ8TV65 | Medicaid:165773433 |
| Other Insurance: MERIDIAN HEALTH PLAN INC MMP | | |

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PRODUCT DESCRIPTION

QUANTITY

Lightweight manual wheelchair
with swing away footrests, safety belt,
adjustable arm rest, heel holder-loops
and anti-tippers.

1

General use wheelchair seat cushion.

1

General use wheelchair back cushion.

1

Height: 5 ft 6 in, Weight:135 lbs

LENGTH OF NEED (# OF MONTHS): 99=LIFETIME

DIAGNOSES:

| | | |
|---|--|--|
| <input type="checkbox"/> Alzheimer's disease | <input type="checkbox"/> Dementia | <input type="checkbox"/> Pendulous Abdomen |
| <input type="checkbox"/> Amputation of _____ | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of Appetite |
| <input type="checkbox"/> Unsteady gait | <input type="checkbox"/> Emphysema/COPD/Asthma | <input type="checkbox"/> Loss of Weight |
| <input type="checkbox"/> Bronchial Asthma | <input type="checkbox"/> Fracture of _____ | <input type="checkbox"/> Renal Failure |
| <input type="checkbox"/> Dysphagia | <input type="checkbox"/> Generalized Body Weakness | <input type="checkbox"/> S/P CVA/Hemiparesis |
| <input type="checkbox"/> Malnutrition | <input type="checkbox"/> Hernia (inguinal) (umbilical) (ventral) | <input type="checkbox"/> Carpal Tunnel Syndrome |
| <input type="checkbox"/> Chronic Incontinence <input type="checkbox"/> Urine <input type="checkbox"/> Stool | <input type="checkbox"/> Organic Brain Syndrome | <input type="checkbox"/> S/P Open Heart Surgery |
| <input type="checkbox"/> CVA | <input type="checkbox"/> Osteoporosis _____ | <input type="checkbox"/> Debility |
| <input type="checkbox"/> CHF | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Spondylosis (cervical) (lumbar) |
| <input type="checkbox"/> Degenerative Osteoarthritis of _____ | <input type="checkbox"/> Parkinson's disease | <input type="checkbox"/> Sprain/Strain of _____ |
| <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> Varicose Veins/ Venous Insufficiency | <input type="checkbox"/> HTN |

I, the undersigned, certify that the above prescribed supplies/equipment are medically necessary for this patient's well being. In my opinion, the supplies are both reasonable and necessary to the accepted standards of medical practice in treatment of this Patient's condition and are not prescribed as convenience supplies. By signing this form, I am confirming that the above information is accurate.

DOCTOR'S INFORMATION

Doctor's Signature: _____ Date: _____
Print Name: _____ NPI#: _____
Facility Name: _____
Address _____
Phone: _____ Fax: _____