

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		
R X	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. General use wheelchair back cushion. 1 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"/> Amputation of _____
<input type="checkbox"/> Unsteady gait
<input type="checkbox"/> Bronchial Asthma
<input type="checkbox"/> Dysphagia
<input type="checkbox"/> Malnutrition
<input type="checkbox"/> Chronic Incontinence <input type="checkbox"/> Urine <input type="checkbox"/> Stool
<input type="checkbox"/> CVA
<input type="checkbox"/> CHF
<input type="checkbox"/> Degenerative Osteoarthritis of _____
<input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> Dementia
<input type="checkbox"/> Dizziness
<input type="checkbox"/> Emphysema/COPD/Asthma
<input type="checkbox"/> Fracture of _____
<input type="checkbox"/> Generalized Body Weakness
<input type="checkbox"/> Hernia (inguinal) (umbilical) (ventral)
<input type="checkbox"/> Organic Brain Syndrome
<input type="checkbox"/> Osteoporosis _____
<input type="checkbox"/> Paralysis
<input type="checkbox"/> Parkinson's disease
<input type="checkbox"/> Varicose Veins/ Venous Insufficiency | <input type="checkbox"/> Pendulous Abdomen
<input type="checkbox"/> Loss of Appetite
<input type="checkbox"/> Loss of Weight
<input type="checkbox"/> Renal Failure
<input type="checkbox"/> S/P CVA/Hemiparesis
<input type="checkbox"/> Carpal Tunnel Syndrome
<input type="checkbox"/> S/P Open Heart Surgery
<input type="checkbox"/> Debility
<input type="checkbox"/> Spondylosis (cervical) (lumbar)
<input type="checkbox"/> Sprain/Strain of _____
<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: _____