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

DETAILED WRITTEN ORDER

Patient's Name:	MARIA RODRIGUEZ	
Address:	10521 S HOXIE AVE FL2 City - State - Zip: CHICAGO, IL 60617	
Phone:	872-203-5522	
DOB:	04/24/1967	
Insurance Name and ID.	Medicare:	Medicaid:180186439
Other Insurance: MERIDIAN HEALTH PLAN INC MMCP		

R x	PRODUCT DESCRIPTION	QUANTITY
	Heavy Duty 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: 5'4'' Weight: 317 LB

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

DIAGNOSES:

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

State of Illinois
Department of Healthcare and Family Services

Standard Manual Wheelchair Questionnaire

Participant's Name Rodriguez Maria RIN 180186439 Birth Date 04-24-1967

Height 5'4" Weight 317 LB Participant's Hip Width 22"

Procedure code and description of wheelchair
K0007 - H/D Manual wheelchair

Weight capacity of wheelchair 500 LB Width of wheelchair 22"

Diagnosis

Current ambulation status

Upper body control and strength

Does participant have the ability to self propel? Yes ☐ No ☐

If not, why?

If the participant is unable to safely self-propel the manual wheelchair does he/she have a caregiver who is available, willing, and able to provide assistance with the wheelchair? Yes ☐ No ☐

Does the participant need wheelchair to meet activities of daily living over the use of a walker or cane? Yes ☐ No ☐

If not, why?

Is this being requested for temporary use for injury or post op? Yes ☐ No ☐

If yes, date of injury or surgery _____ Expected duration of need _____

*All requests for renewal of post surgical/post injury wheelchairs will require updated MD script along with copy of MD clinical follow-up progress note.

Will this manual wheelchair meet participant's long term needs (3-5 years) or will participant need a customized wheelchair?

Physician's Name _____ Telephone Number _____

Attending Physician's Signature _____ Date Signed

HFS 3701L (N-8-13)