709 Washington Street
Weymouth, Ma 20188
PH (781)331-0091
FAX (781)331-6088

APEX MEDICAL PRODUCTS, INC

WHEELCHAIR ORDER / FACE TO FACE

Medicare requires a face to face sheet as proof that a doctor has discussed how the patient will benefit from the wheelchair. Please fill this out to the best of your knowledge and the bottom is signed by the ordering doctor.

PATIENT NAME_____ **DISCHARGE DATE** _____/_____/_____

ORDERED BY_____ **DISCHARGE TIME**_____

PHONE (_____)_____ **FACILITY NAME** _____
If the patient is not admitted to a facility please write N/A

I CERTIFY THAT THERE WAS A FACE TO FACE MEETING BETWEEN MYSELF _____
MD/CLINICIAN

AND THE PATIENT STATED ABOVE ON THIS DAY OF _____/_____/_____.

PATIENT NAME_____ **DELIVER TO HOME** YES NO

DATE OF BIRTH_____/_____/_____ **FACILITY OR HOME DELIVERY ADDRESS**

_____

HEIGHT____'____"__**WEIGHT**_____lbs

CITY_____MA__**ZIP**_____

DIAGNOSIS_____ **PHONE FOR DELIVERY** (_____)_____

WHEELCHAIR
PLEASE CIRCLE ALL THAT APPLY

❖ **SIZE:** 16' 18' 20' 22' ❖ **TYPE:** STANDARD LIGHTWEIGHT HEAVY DUTY

❖ **ARM LENGTH:** DESK FULL ❖ **FOOT RIGGING**: FOOTREST ELEVATING LEGS

WHEELCHAIR ACCESSORIES AND ADD ONS
PLEASE CIRCLE ALL THAT APPLY

CUSHION ANTITIPPERS WHEELCHAIR BACK SEATBELT BRAKE EXTENSIONS

THE ATTACHED PRESCRIPTION APPLIES TO THE ABOVE EQUIPMENT FROM (date) _____/_____/_____TO INDEFINITE

PROGNOSIS_____ **LENGTH OF NEED** _____
1-99 (99 = lifetime)

I, _____, certify that the above prescribed equipment is medically necessary for this patient's wellbeing. It is my
Physician's name
professional opinion that the equipment is both reasonable and necessary in reference to accepted standards of medical practice in treatment

of _____'s condition and it is *not* prescribed as convenience equipment.
Patient's name

Physician's Signature_____ **NPI**_____

Print Physician's name_____