APRIA®

Wheelchair Order Form

Fax completed form to: _____

Apria Representative _____ **Branch Location** _____ **Phone** _____

REFERRAL SOURCE

Referral name _____ Referral contact name _____

Order date _____ Phone _____ Fax _____

PATIENT INFORMATION

Patient name _____ DOB _____
Last First

Home phone _____ Mobile phone _____ Email _____

Delivery address: Street _____ City _____ State _____ Zip _____

Estimated length of need: _____ months (99 = lifetime) Hip width _____ Leg length _____ Height _____ Weight _____

Diagnosis ICD-10: Each diagnosis requires a corresponding ICD-10 code and must be corroborated in the patient's medical record. Please enter the appropriate qualifying diagnoses and corresponding ICD-10 codes. (Note: ranges are not acceptable.) _____

PLEASE PROVIDE SUPPORTING DOCUMENTATION FROM THE MEDICAL RECORD AND PATIENT DEMOGRAPHICS AND INSURANCE INFORMATION

All qualifying criteria MUST BE DOCUMENTED in the patient's medical record.

Wheelchairs are covered items if:

- The patient has a mobility limitation that significantly impairs his/her ability to participate in one or more Mobility Related Activities of Daily Living (MRADLs) in the home. MRADLs are toileting, feeding, dressing, grooming, and bathing performed in customary locations in the home. A mobility limitation is one that:
  - Prevents the patient from accomplishing the MRADLs entirely, ***or***
  - Places the patient at a reasonably determined heightened risk of illness, injury, or death secondary to the attempts to participate in MRADLs, ***or***
  - Prevents the patient from completing the MRADLs within a reasonable time frame, ***and***
- The patient's mobility limitation cannot be resolved with the use of a cane or walker, ***and***
- The patient's home environment can safely support the use of the equipment and provides adequate access between rooms, maneuvering space, and surfaces for use of the wheelchair provided, ***and***
- Use of a wheelchair will significantly improve the patient's ability to participate in MRADLs and the patient will use it on a regular basis in the home, ***and***
- The patient has sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the manual wheelchair during a typical day, ***or***
- The patient has a caregiver who is available, willing, and able to provide assistance with the wheelchair.

EQUIPMENT ORDERED

- ☐ Standard wheelchair (E1140, K0001)
- ☐ Standard hemi (low seat) wheelchair, Pt. requires lower seat height of 17" to 18" (E1084, K0002)
- ☐ Lightweight wheelchair, Pt. cannot self-propel in standard wheelchair but can self-propel lightweight one (E1260, K0003)
- ☐ Heavy-duty wheelchair. Pt. weight > 250 lbs. or patient has severe spasticity (E1290, K0006)
- ☐ Extra heavy-duty wheelchair, Pt. weight > 300 lbs. (E1092 – E1093, K0007)
- ☐ Pediatric wheelchair with seat width and/or depth of ≤ 14" (E1236)
- ☐ Elevating leg rests, pair, Pt. has musculoskeletal condition or cast/brace that prevents 90-degree flexion at the knee, or significant lower extremity edema, or meets criteria for reclining back wheelchair (E0990, K0195)
- ☐ Anti-tipping device (E0971, K0021)
- ☐ Safety belt (E0978, K0031)

Seat cushions:

- ☐ General gel foam, Pt. weight <275 lbs. (E2601)
- ☐ Skin protection gel foam, Pt. weight < 500 lbs. (E2602)
- ☐ Skin protection gel foam, Pt. weight < 275 lbs. (E2603)
- ☐ Gel-U-Seat/Gel foam bari, Pt. weight < 500 lbs. (E2604)
- ☐ AirLITE with HD cover (E2605)

Non-standard seat frame:

- ☐ Width greater than or equal to 20" and less than 24" (E2201)
- ☐ Width of 24" to 27" (E2202)
- ☐ Depth of 20" to less than 22" (E2203)
- ☐ Depth of 22" to 25" (E2204)

By my signature below, I authorize the use of this document as a dispensing prescription. I understand that the final decision with respect to ordering this (these) item(s) for this patient is a clinical decision made by me, based on the patient's clinical needs, and that my records concerning this patient support the medical need for the items prescribed.

Print prescriber's name _____ **Prescriber email** _____ **NPI #** _____

Prescriber's signature _____ **Date** _____

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