

JONES MEDICAL EQUIPMENT

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*****ALL PHYSICIANS SCRIPTING FOR MEDICARE AND MEDICAID MUST BE PECOS CERTIFIED AND ENROLLED WITH GAMMIS. INFORMATION WILL BE VERIFIED DURING THE INTAKE PROCESS AND DENIED, IF YOU'RE NOT ENROLLED*****

Manual Wheelchair and Accessories

Patient Name _____ DOB _____

Insurance _____ MBI # _____

Order Date _____ End Date _____

Treating Provider _____ NPI _____

Phone # _____ Fax # _____

Equipment Ordered (Circle All that Apply)

K0001 Standard Wheelchair	K0006 Heavy Duty, <250lbs
K0002 Standard Hemi (low seat) Wheelchair	K0007 Extra Heavy Duty, <300lbs
K0003 Lightweight Wheelchair	E1038 Transport Chair, >300lbs
K0004 High Strength, Lightweight Wheelchair	E0139 Transport Chair <300lbs
K0005 Ultra Lightweight Wheelchair	E2601 Seat Cushion
E2611 Back Cushion	K0734 Rojo Cushion
E0951 Heel Loops	E0971 Anti Tippers
K0195 Elevating Leg Rest --- RT___ LT___	

To be completed (must be signed by the ordering M.D.)

Prognosis (circle) Fair Good Poor Length of Need _____ (99= lifetime)

Date of Order (RX) _____ Date of Office Visit _____

DX _____ ICD-10 Code _____

Patient Height _____ Patient Weight _____

Please check the correct answer below:

- Does the patient have a mobility limitation that significantly impairs his/her ability to participate in one or more mobility related activities (MRADLs) such as toileting, grooming, dressing and bathing in a customary location within the home? Yes No
- Does an appropriately fitted cane or walker sufficiently resolve the patient's mobility limitation? Yes No
- Does the patient's home provide adequate space between rooms, maneuvering space and surfaces for use of the manual wheelchair in the home? Yes No
- Will the use of the manual wheelchair significantly improve the patient's ability to participate in MRADLs and will the patient use the chair on a regular basis? Yes No
- Has the patient expressed willingness to use the chair that is provided, in the home? Yes No
- Does the patient have sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the manual wheelchair that is provided in the home during a typical day? Yes No
- Does the patient have a caregiver that is willing and able to provide assistance with the chair? Yes No
- Is the patient at risk for skin breakdown or decubitus ulcers? Yes No

PROVIDER SIGNATURE

DATE

Individually Owned and Operated