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*****

Power Mobility Device- Initial Order

Patient Name _____ DOB _____

Insurance _____ MBI # _____

Date of Face to Face Exam _____ Order Date _____

Diagnosis _____ ICD-10 _____

Diagnosis _____ ICD-10 _____

Patient Height _____ Weight _____ Last weighed _____

Length of need _____ Prognosis (circle) Fair Good Poor

HCPC/ QTY	General Description	Charge	Allow
_____	_____	_____	_____
_____	_____	_____	_____

Treating Provider _____ NPI _____

Phone # _____ FAX # _____

Please check the correct answer below:

1. 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
2. Does an appropriately fitted cane, walker or manual wheelchair sufficiently resolve the patient's mobility limitation? Yes No
3. Does the patient's home provide adequate space between rooms, maneuvering space and surfaces for use of the POV? Yes No
4. Will the use of the POV significantly improve the patient's ability to participate in MRADLs and will the patient use the chair on a regular basis inside the home? Yes No
5. Has the patient expressed willingness to use the chair that is provided, in the home? Yes No
6. Does the patient have sufficient mental and physical capabilities needed to safely transfer to and from the POV safely in the home during a typical day? Yes No
7. Does the patient have a caregiver that is willing and able to provide assistance with the chair? Yes No
8. Is the patient at risk for skin breakdown or decubitus ulcers? Yes No

Provider Signature _____ Date _____