TODAYS DME INC
1312 Redwood Ave Ph 541-249-9860
Grants Pass OR 97527 Fx 541-249-9859
melody.hannah@todaydme.com

Detailed Written Order Prior to Delivery

Patient Name: _____ Patient DOB: _____

Order Date: _____

PLEASE COMPLETE ALL 3 PAGES OF THE DWO

Chart notes Attached (chart notes must include the need for equipment being ordered

I, the undersigned, certify that the below prescribed equipment/supplies is medically necessary as part of my treatment plan for this patient. In my opinion, the equipment prescribed is reasonable and necessary for accepted standards of medical practice and treatment of this patient's condition and has not been prescribed as "convenience equipment". I have documented the following information and the need for this equipment in the patient's most recent chart notes.

DIAGNOSIS (Check appropriate diagnosis below) Length of Need: ☐ 12 months ☐ 99 months

ICD-10 Diagnosis Code(s): _____

Wheelchair Products & accessories are medically necessary (Check equipment/supplies ordered)

QTY	HCPC Code	Description of specific services to be provided
☐	E1031	Rollabout chair with casters 5" or greater
☐	E1037	Pediatric Transport Chair – ASK FOR DIFFERENT DWO
☐	E1038	Adult Transport Chair 300 lbs and under
☐	E1039	Adult Transport Chair 301 lbs and over
☐	E1161	Adult Manual wheelchair includes Tilt in Space (20 degrees or greater tilt)
☐	K0001	Standard Wheelchair 250 lbs or less, seat height 19" or greater
☐	K0002	Standard Hemi Low Seat Wheelchair 250 lbs or less, seat height 19" or less
☐	K0003	Lightweight Wheelchair 250lbs or less
☐	K0004	High Strength lightweight wheelchair
☐	K0005	Ultralight wheelchair
☐	K0006	Heavy Duty Wheelchair 250 lbs or greater
☐	K0007	Extra Heavy Duty Wheelchair 300lbs or greater

☐	E1226	Manual fully reclining back greater than 80 degrees
☐	K0195	Elevating leg rests
☐	E0951	Heel Loop/Holder with/without ankle strap each
☐	E0973	Arm Detachable Desk adj height (each R/L)
☐	E0978	Seat Belt – Auto Clasp OR Velcro, Standard OR Bariatric
☐	E2601	Standard Seat Cushion Seat Width _____
☐		RoHO Seat Cushion Seat Width _____
☐	E2208	O2 cylinder holder
☐	E0971	Anti Tippers **with wheels** / Without wheels
☐	E0961	6" Wheel lock extension
☐	E2611	General use back cushions
☐		RoHo back cushions
☐	E2201	Nonstandard seat frame, width greater than/equal to 20" and less than 24"
☐	E0990	Elevating leg rest
☐	E1161	Adult Tilt-in-space wheelchair
☐	E1020	Residual Limb support system for wheelchair (R/L) (for both need QTY 2)

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Additional Information: Criteria A, B, C, D, and E are met, and Criterial F or G is met

A) 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) such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home. A mobility limitation is one that:	☐ YES	☐ NO
A1) Prevents the beneficiary from accomplishing an MRADL entirely or	☐ YES	☐ NO
A2) Places patient at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform the MRADL **OR**	☐ YES	☐ NO
A3) Prevents the patient from completing the MRADL within a reasonable time frame	☐ YES	☐ NO
B) The Patient mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker	☐ YES	☐ NO
C) the beneficiary's home provides adequate access between rooms, maneuvering space, and surfaces for use of the manual wheelchair that is provided.	☐ YES	☐ NO
D) Use of a manual wheelchair will significantly improve the beneficiary's ability to participate in MRADLs and the beneficiary will use it on a regular basis in the home	☐ YES	☐ NO
E) The patient has not expressed an unwillingness to use the manual wheelchair that is provided in the home.	☐ YES	☐ NO

F) The beneficiary has 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. Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function.	☐ YES	☐ NO
G) The patient has a caregiver who is available, willing, and able to provide assistance with the wheelchair.	☐ YES	☐ NO
H) Does the patient's height exceed 6ft?	☐ YES	☐ NO
I) What does the patient weight _____ lbs	☐ YES	☐ NO
J) K0002 – Does the patient require a lower seat height (17'' to 18") because of short stature or to enable the patient to place feet on the ground for propulsion	☐ YES	☐ NO
K) K0003 – must meet both K1 and K2		
K1) The patient cannot self-propel in a standard wheelchair in the home AND	☐ YES	☐ NO
K2) The patient can and does self-propel in a lightweight wheelchair	☐ YES	☐ NO
L) K0004 - must either L1 OR L2 and the need is longer than 3 months		
L1) The patient self-propels the wheelchair while engaging in frequent activities in the home that cannot be performed in a standard or lightweight wheelchair	☐ YES	☐ NO
L2) The patient requires a seat width, depth, or height that cannot be accommodated in a standard, lightweight or hemi-wheelchair, and spends at least two hours per day in the wheelchair	☐ YES	☐ NO
M) K0005 – must meet M1, M2, M3, and M4	☐ YES	☐ NO
M1) The patient must be a full-time manual wheelchair user	☐ YES	☐ NO
M2) The patient must require individualized fitting and adjustments for one or more features such as, but not limited to, axle configuration, wheel camber, or seat and back angles, and which cannot be accommodated by a K0001 through K0004 manual wheelchair.	☐ YES	☐ NO
M3) the patient must have a specialty evaluation that was performed by a licensed/certified medical professional (LCMP) such as a PT/OT, MD who has	☐ YES	☐ NO

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specific training and experience in rehabilitation wheelchair evaluations and that documents the medical necessity for the wheelchair and its special features		
M4) the wheelchair is provided by a RTS that employs a RESNA-ATP who specialized in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the patient.	☐ YES	☐ NO
N) K0006 – Patient weighs more than 250 lbs or has severe spacticity	☐ YES	☐ NO
O) K0007 – Patient weights more than 300 lbs	☐ YES	☐ NO
P) E1161 – Must meet both P1 and P2	☐ YES	☐ NO
P1) the patient must have a specialty evaluation that was performed by a licensed/certified medical professional (LCMP) such as a PT/OT, MD who has specific training and experience in rehabilitation wheelchair evaluations and that documents the medical necessity for the wheelchair and its special features	☐ YES	☐ NO
P2) the wheelchair is provided by a RTS that employs a RESNA-ATP who specialized in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the patient.	☐ YES	☐ NO

Prescribing Physician's Information

Name & Credentials _____ NPI# _____

Telephone _____ Fax _____

Address _____

Signature _____ Signature Date _____