Physicians Mobility Order Form

Patients Name: ________________________ **Start Date:** ________________

Address: ________________________ **City:** ____________ **State:** ____________ **Zip:** ________

Height: ____________ **Weight:** ____________ **DOB:** ____________

Insurance #1: ________________________ **Insurance #2:** ________________________

Mobility Aides

☐ Crutches (E0114) ☐ Cane (E0100) ☐ Quad Cane (E0105) ☐ Walker (Pick-up) (E0135)

☐ Walker w/ Wheels (E0143) ☐ Heavy Duty Walker (E0148) ☐ Heavy Duty Walker w/ Wheels (E0149)

☐ Rollator Walker w/ Seat (E0143) & (E0156) ☐ Rollator Heavy Duty Walker w/ Seat (E0147) & (E0156)

☐ Hemi Walker (E0135) ☐ Platform Attachment (E0154) ☐ Crutch Attachment (E0157)

Wheelchair

☐ Wheelchair STD (K0001) ☐ Wheelchair Hemi (K0002) ☐ Wheelchair Light Weight (K0003)

☐ Wheelchair Light High Strength (K0004) ☐ Wheelchair HD (K0006) ☐ Wheelchair Extra HD (K0007)

☐ Transport Wheelchair (E1038) ☐ Reclining Wheelchair (E1226)

Accessories

☐ ELR's - **Right** ☐ **Left** ☐ **Bilateral** ☐ **(Check one)** (E0990) (K0195) ☐ Ant Tippers (E0971)

☐ Brake Extensions (E0961) ☐ Cushion Back (E2601) ☐ Cushion Seat (E2611)

☐ Adjustable Arm Rest (E0973) ☐ Seat Belt (E0978) ☐ Heel Loops for Footrest (E0951)

*****Qualifications and required documentation to be noted in Face-to-Face chart notes from Physician*****

ICD-10: ________________________ **LON:** ________________________

Physician or FNP Name: ____

Address: ________________ **City:** ____________ **State:** ____________ **Zip:** ________

Phone: ________________________ **Fax:** ________________________

NPI #: ____________________

Physician or FNP Signature: ________________________ **Date:** ____________