Kesling Home Health Care
1115 W Market Street
Logansport, IN 46947
Fax: (574) 753-3910
NPI: 1568642056 TID:35-1994022

Physician's Order for Manual Wheelchair

Patient: _____ **DOB:** _____
Address: _____
Phone: _____
Diagnosis: _____ **Length of Need:** _____

Does patient require the use of a wheelchair to complete ADL's in the home?
[ ] Yes [ ] No

[ ] Standard Wheelchair (K0001) patient < 250 lbs
[ ] Heavy Duty Wheelchair (K0006) patient >250 lbs
[ ] Bariatric Wheelchair (K0007) patient >300 lbs

Patient weight at face-to-face evaluation _____ lbs

[ ] Wheelchair Seat Cushion [E2601]
[ ] Wheelchair Back Cushion [E2611]
[ ] Adjustable Height Arms [E0973]
[ ] Elevating Legrests [K0195]
[ ] Anti-Tippers [E0971]
[ ] Wheel Lock Extensions [E0961]
[ ] Seat Belt [E0978]
[ ] Heel Loops [E0951]

I, undersigned, certify that the above prescribed equipment and or supplies are medically necessary as part of my treatment for this patient. In my opinion, the equipment and or supplies prescribed are both reasonable and necessary for the accepted standards of medical practice and treatment of this patients condition. Neither the equipment and or supplies are being prescribed as "convenience equipment."

X_____ **X**_____
Physician's Signature **Date**
(Please print Physician's Information)

Name: _____ **NPI:** _____

Address: _____

Phone: _____ **Fax:** _____

** Please attach visit notes from face-to-face visit when wheelchair and any accessories ordered were discussed with patient. A face-to-face visit is required to meet criteria for insurance coverage. Private pay options are always available for patient's who do not meet insurance guidelines but would still benefit from use of a wheelchair.