Continuum
a CHC Solutions Company

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# WHEELCHAIR ORDER FORM

***Please attach face sheet w/ patient demographics & insurance info****

## PATIENT INFORMATION

Patient Name: _____ DOB: _____/_____/_____ Gender: ☐ Male ☐ Female

Language Pref.: ☐ English ☐ Spanish ☐ Other: _____

Height: _____ Weight:_____

Patient cannot accept deliveries on the following days?
☐Mon ☐Tues ☐Wed ☐Thurs ☐Fri ☐Sat

## DIAGNOSIS

**Primary Diagnosis**
**ICD-10 Code:** _____
*Non-Specified Codes will not qualify for Primary Diagnosis

**Secondary Diagnosis**
**ICD-10 Code:** _____

## EQUIPMENT:

Type of chair:_____

Size of chair:_____

Does this patient require any add-ons? ☐ Yes ☐ No

**If yes, what kinds?:**_____

Please answer questions below in regards to the equipment ordered for this patient.

Is the patient able to ambulate? ☐ Yes ☐ No

**If yes, how far?:**_____

Is the patient able to ambulate up stairs? ☐ Yes ☐ No

Is the patient able to ambulate with the use of a cane or walker? ☐ Yes ☐ No

Is the patient/caregiver able to propel the wheelchair? ☐ Yes ☐ No

Would the patient be confined to a bed or chair without equipment? ☐ Yes ☐ No

Does patient need a wheelchair to navigate their residence? ☐ Yes ☐ No

**Order Date: _____/_____/_____**

**Length of Need: _____ months**

## REFERRAL INFORMATION

**Ref #:** _____

Practice Name: _____ Fax: _____

Office Address: _____ Email: _____

Phone: _____ Preferred Method of Contact? ☐ Phone ☐ Fax ☐ Email

Contact Person: _____

Physician Name: _____ NPI#: _____ Phone: (_____)_____-_____ Ext. _____

Physician Signature: _____ Date: _____/_____/_____

*I certify that the above products are medically necessary and that the information provided is accurate to the best of my knowledge. By signing below, I acknowledge that I have obtained the patient's authorization to release the above information and other medical information that may be disclosed. I certify that my decision to prescribe this recommended product was solely based on my determination of medical necessity set forth herein. This document may serve as a confirmation of a verbal order and is also recorded in the patient's record.*

Assignment of Benefits: *I request that payment of my insurance benefits be made to CHC Solutions, Inc., or any of its subsidiaries, for any supplies or services they provide me. I am responsible for any balance due that is not covered by my insurance. I understand any product received in my home cannot be returned if opened. By signing below, I authorize the distribution of my information to CHC Solutions, Inc., or any of its subsidiaries, which may be needed to determine benefits payable for these services or supplies. I authorize CHC Solutions, Inc., or any of its subsidiaries, to forward my medical records to the medical professionals in my care and/or make copies of said records.*

Patient Signature: _____ Date: _____/_____/_____