HANDI MEDICAL SUPPLY

Standard Written Order: Manual Wheelchair

Prescriber Information

Clinic/Location Name:
Prescriber Name:
Prescriber Address:
Prescriber City State Zip:
Prescriber Phone:
Prescriber Fax:
Prescriber NPI:

Patient Information

Patient Name:
Patient Address:
Patient City State Zip:
Phone:
DOB:
Primary Insurance:
Handi Customer Number:

Patient height: _____ **Patient weight:** _____

HCPC	DESCRIPTION	DISPENSING QTY
☐ K0001	STANDARD WHEELCHAIR	1 EA PER 5 YEARS
☐ K0002	STANDARD HEMI (LOW SEAT) WHEELCHAIR	1 EA PER 5 YEARS
☐ K0003	LIGHTWEIGHT WHEELCHAIR	1 EA PER 5 YEARS
☐ K0004	HIGH STRENGTH, LIGHTWEIGHT WHEELCHAIR	1 EA PER 5 YEARS
☐ K0006	HEAVY DUTY WHEELCHAIR, WT CAPACITY >250	1 EA PER 5 YEARS
☐ K0007	EXTRA HEAVY DUTY WHEELCHAIR, WT CAPACITY >300	1 EA PER 5 YEARS

Select additional needed components

☐ E0973	ADJUSTABLE HEIGHT, DETACHABLE ARMREST	
☐ K0195	ELEVATING LEG RESTS, PAIR	
☐ E0971	ANTI-TIPPING DEVICE	
☐ E0978	POSITIONING BELT/SAFETY BELT/PELVIC STRAP	
☐ E2601	GENERAL USE WHEELCHAIR SEAT CUSHION	
☐ E2611	GENERAL USE WHEELCHAIR BACK CUSHION	

NOTE: If multiple HCPCs are listed this indicates insurance coverages utilizes different HCPCs for claims processing

1. **Ordered Date:** _____
2. **Length of Need:** _____

   Leaving blank presumes Lifetime (99 months)

3. _____ _____

   Physician/NP/PA/Medical Practitioner Signature — Date

: Signer must match Prescriber Information at the top of this form, or be updated below

Print New Prescriber Name: NPI: