Order Form for Mobility Assistive Equipment (MAE)

DME Order

Call our office at **(612) 223-8644** with questions. Incomplete forms will be returned. **Fax back completed form to (612) 223-8661**

Member information

First Name _____ MI _____ Last Name _____

Insurance ID # _____ DOB _____

Requester information

Form completed by: First Name _____ Last Name _____

Your business name _____

Your business street address _____

Your business city _____ Your business state _____ Your business zip _____

Phone* _____ Fax** _____

Ordering physician information

Physician first name _____ Physician last name _____

Specialty _____ NPI _____

Clinic Name _____

Clinic Street Address _____

Clinic City _____ Clinic state _____ Clinic zip _____

_____

Email _____ Phone* _____ Fax** _____

Vendor Information

Vendor name INSIGHT MEDICAL SUPPLY, INC

Vendor street address 6603 Queen Ave STE R

Vendor City Richfield Vendor state MN Vendor zip 55423

_____

Phone 612-223-8644 Fax 612-223-8661

Durable Medical Equipment

Primary diagnosis code _____ Description _____

Secondary diagnosis code _____ Description _____

For continued rental, how many more months is Mobility Equipment needed?

_____

For initial requests, length of need: _____

Current symptoms, related diagnosis and history (describe the reason for the wheelchair):

_____

_____

_____

_____

Height:_____ Weight:_____

Neck, trunk, and pelvic posture and flexibility: ☐ Good ☐ Limited ☐ Severely limited

Where does the member live? ☐ House/apartment ☐ SNF/TCU ☐ Assisted living

☐ Other (describe): _____

1. Can mobility limitation be sufficiently resolved by the prescription of a cane or walker? ☐ Yes ☐ No

Questions 2-4 refer to MRADLs (Mobility-related activities of daily living): eating, dressing, grooming, toileting and bathing performed in customary locations

1. Are there mobility limitations that significantly impair the member's ability to participate in MRADLs and will the MAE compensate for the limitations? ☐ Yes ☐ No

2. Is the member or a caregiver capable and willing to operate/maneuver MAE, POV, scooter or power wheelchair safely, and participate in MRADLs? ☐ Yes ☐ No

3. Does the member have sufficient upper extremity function to safely propel a manual wheelchair to participate in MRADLS? ☐ Yes ☐ No

4. If a power wheelchair is requested, does the member need the additional features (i.e. optimal maneuverability, upgradeable/adaptable seating, etc.) of a power wheelchair to participate in MRADLs? ☐ Yes ☐ No

Questions 5-18 refer to specific types of manual wheelchairs (Specify which type of wheelchair is needed):

Hemi/low wheelchair (K0002):

5. Does the member require a lower seat height (17" to 18") because of a short stature? ☐ Yes ☐ No
6. Does the hemi height enable the member to place his/her feet on the ground for propulsion? ☐ Yes ☐ No

Lightweight wheelchair (K0003):

7. Can and does the member self-propel in a standard wheelchair in the home? ☐ Yes ☐ No
8. Can and does the member self-propel in a lightweight manual wheelchair? ☐ Yes ☐ No
9. Is the member at risk for shoulder pain or injury related to self-propelling a standard wheelchair? ☐ Yes ☐ No

High strength hemi wheelchair (K0004):

10. Does the member self-propel the wheelchair while engaging in frequent activities in the home that cannot be performed in a standard or lightweight wheelchair? ☐ Yes ☐ No
11. Does the member require a seat width, depth, or height that cannot be accommodated in a standard, lightweight, or hemi-wheelchair? ☐ Yes ☐ No
12. Is the high strength wheelchair needed for safety due to a medical condition? ☐ Yes ☐ No
    If yes, please describe: _____
13. Will the member spend at least 2 hours a day in the wheelchair? ☐ Yes ☐ No

Ultra-lightweight wheelchair (K0005):

14. Is the member a full-time wheelchair user? ☐ Yes ☐ No
15. Does the member require individualized fitting and adjustments that cannot be accommodated by a K0001-K0004 manual wheelchair? ☐ Yes ☐ No
16. Is the member at risk for shoulder pain or injury related to self-propelling a standard wheelchair? ☐ Yes ☐ No

Heavy duty wheelchair (K0006):

17. Does member have a medical condition such as spasticity, which requires a heavier duty chair for safety?
    ☐ Yes ☐ No
    If yes, please describe:

_____

_____

_____

Additional Information

_____

_____

_____

I confirm that the information above is correct.

Physician or Treating Practitioner Signature: _____ **Date:** _____