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INNOVA MEDICAL PRODUCTS

TRANSPORT CHAIR PRESCRIPTION FORM

Patient Name _____ Phone _____

Address _____

Email _____

Diagnosis codes _____ Length of Need _____

DOB _____ Ht _____ Wt _____ Start Date _____

Alternate Contact Name _____ Relationship _____ Phone _____

Equipment ordered:

_____ E1038 Transport Chair

Coverage Questions for Transport Chair:

- Y N Does the patient have a mobility limitation that significantly impairs his/her ability to participate in one or more mobility related activities of daily living such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home?
- Y N Can the patient's mobility limitation be sufficiently resolved by the use of an appropriately fitted cane or walker?
- Y N Does the patient's home provide adequate access between rooms, maneuvering space, and surfaces for use of the transport chair that is being provided?
- Y N Will the use of the transport chair significantly improve the patient's ability to participate in MRADLs and the patient will use it on a regular basis in the home?
- Y N Has the patient expressed an unwillingness to use the transport chair that is provided in the home?
- Y N Does the patient have a caregiver who is providing 24 hour a day care, and is willing and able to provide assistance with the transport chair?
- Y N Is the patient unable to use a wheelchair?

**PLEASE PROVIDE A COPY OF THE CLINICAL NOTES FROM THE FACE-TO-FACE VISIT
(ALL CLINICAL NOTES MUST BE EITHER ELECTRONICALLY SIGNED OR HAVE A WET SIGNATURE)**

Physician Name _____ NPI _____

Address _____

Phone _____ Fax _____

Physician Signature _____ Date _____