INNOVA MEDICAL PRODUCTS

Northeast Medical Products, Inc

DME Order Checklist for Referring Providers

Please fax the following information to help us process your Durable Medical Equipment (DME) order quickly and accurately. Incomplete submissions are the most common cause of processing delays.

- ☐ **Patient demographics**
- ☐ **Completed Rx form**, signed and dated with either a wet signature or "Electronically signed by..."
- ☐ **Current insurance information**, with copy of front and back of insurance card
- ☐ **Medical records dated within the last 6 months**, indicating need for the equipment

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Before You Fax

- ☐ Confirm all pages are legible and complete
- ☐ Confirm the order is signed and dated by the prescriber
- ☐ Confirm all quantities are correct
- ☐ Confirm diagnosis codes, number of refills, and length of need are on the Rx and all coverage questions have been completed
- ☐ Include a cover sheet noting the number of pages and a callback number in case we have questions

Fax to: 860-388-0368

Questions? Call us at: 860-388-1437

This checklist is a general guide. Specific documentation requirements can vary by insurance payer and equipment type — our team will follow up if anything additional is needed.

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www.northeastmedicalproducts.com
An Innova Medical Group Company

WHEELCHAIR PRESCRIPTION FORM

Patient Name _____ Phone _____

Address _____

Email _____

Diagnosis codes _____ Ht _____ Wt _____

DOB _____ Length of Need _____

Alternate Contact: Name _____ Relationship _____ Phone _____

Equipment ordered:

____ **K0001 Standard Wheelchair**

____ **K0002 Standard Hemi (low seat) wheelchair** (please answer question below)

Y N The patient requires a lower seat height (17" to 18") because of short stature or to enable the patient to place his/her feet on the ground for propulsion.

____ **K0003 Lightweight Wheelchair** (please answer question below)

Y N The patient cannot self-propel in a standard weight wheelchair in the home and can self-propel in a lightweight wheelchair.

____ **K0006 Heavy Duty Wheelchair** (over 250lbs)

____ **K0007 Extra Heavy-Duty Wheelchair** (over 300lbs)

Wheelchair Accessories

____ K0195 Elevating Leg Rests
____ E2601 Wheelchair Seat Cushion
____ E1226 Fully Reclining Back
____ E0705 Transfer Board
____ E2611 Wheelchair Back Cushion
____ E0971 Anti-Tipper

Coverage Questions for Any Wheelchair:

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 manual wheelchair that is being provided?

Y N Will the use of the manual wheelchair 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 manual wheelchair that is provided in the home?

Y N Does the patient have sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the manual wheelchair that is provided in the home during the typical day?

Y N Does the patient have a caregiver who is available, willing, and able to provide assistance with the wheelchair?

Coverage Questions for Elevating Leg Rests:

Y N Does the patient have a musculoskeletal condition or the presence of a cast or brace which prevents 90-degree flexion at the knee?

Y N Does the patient have significant edema of the lower extremities that requires an elevating legrest?

Coverage Questions for Reclining Back:

Y N Is the patient at high risk for pressure ulcer development and unable to perform a functional weight shift?

Y N Does the patient require intermittent catheterization for bladder management and cannot independently transfer from the wheelchair to the bed?

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

Physician Name _____ NPI _____

Address _____

Phone _____ Fax _____

_____ _____
Physician Signature Date