PRESCRIPTION

PHYSICIAN'S INFORMATION
NAME:
ADDRESS:
PHONE:
FAX:

PATIENT INFORMATION
NAME:
ADDRESS:
PHONE:

DESCRIPTION OF REQUESTED DME:
Power Wheelchair

DX:

LENGTH OF NEED:

 # Months _____ OR Lifetime
(99 Months)

Notes:

BY SIGNING BELOW, I AUTHORIZE the use of this document as a legal prescription, and I certify that the above prescribed equipment is medically necessary and reasonable, and is not being purchased for convenience. I will maintain an original signed copy of this order in my medical records and make it available to Medicare, their authorized agents or other insurer, if required.

X _____ _____

Physician's Signature Date