# Power Mobility Device - 7 Element Written Order

****NOTE:** Medicare requires ALL 7 elements must be handwritten by the ordering physician.
** **NOTE:** All corrections must be initialed and dated(White out/ Correction Tape is NOT permitted.)

**1** _____
Patient Name / Beneficiary Name

**2** _____
Equipment Ordered

**3** _____
Date of Face-to-Face Mobility Examination

**4** Condition / Diagnosis relating to device prescribed

Weight :_____

Height: _____

(To Select correct equipment)

| ICD-10 CODE | | DIAGNOSIS |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**5** Length of Need:_____ # of months
(99= lifetime)

**6** _____
Physician's Signature
No signature stamps

_____ _____
Physician Printed Name ***NPI NO***

**7** _____
Date of Physician's Signature

***Before you send completed written order, does it include ALL 7 Elements***

**MISSION MEDICAL SUPPLY**
4444 El Cajon Blvd Ste. 3 - San Diego, CA. 92115
Tel: 619-229-9597 Fax: 619-229-9594

# RETURN FAX COVER SHEET

**From:** _____ **To:** **Mission Medical Supply**

**Fax:** _____ **Fax:** 619-229-9594

**Phone:** _____ **Phone:** 619-229-9597

Please fill in your patient's information

Patient Name: _____
Last Name First Name DOB

_____
Address City Sate Zip

Patient Phone: ( ) _____

**Mobility Examination Date:** _____

## PLEASE USE THIS SHEET AS A MOBILITY CHECKLIST AND A RETURN FAX COVER SHEET.

Please check all the items that are being faxed back to Mission Medical Supply

- ☐ Chart Notes From Face-To-Face Mobility Examination
  * Includes all documentattion as required by Medicare
- ☐ Prescription for Power Mobility Device
  * Includes all 7 Elements
- ☐ Please provide the last 12 months of chart notes for your patient if possible