

Does the patient's living environment support the use of a manual wheelchair? YES NO

Is the patient able and willing to consistently operate the wheelchair safely and effectively? YES NO

Does the patient have stamina to use a manual wheelchair? YES NO

Approximate length of time in chair per day: _____hrs per day

Equipment Start Date: _____

Is the equipment: New Used

How long will the patient require custom wheelchair/electric scooter? ____ Weeks ____ Months ____ Indefinite

*Please select the type of custom wheelchair/electric scooter:

Standard Wheelchair

Heavy Duty Wheelchair

Lightweight Wheelchair

Power/motorized Wheelchair

	HCPC	Purchase	Rental	Circle One
Type selected above		\$	\$	per day / week / month
Attachment(s)		\$	\$	per day / week / month
Attachment(s)		\$	\$	per day / week / month
Other		\$	\$	per day / week / month

Provider Contact Information

Contact Person: _____

Title: _____

Phone: _____

Fax: _____

**The Plan has a preferred provider for DME Services. In order to receive the maximum benefit, the preferred provider must be used.*