WHEELCHAIR PRESCRIPTION FORM

Physicians: ***Please fax referral and face sheet to 559.713.6012***
Patients: ***Please call 559.713.6461 to schedule***

Patient Information:

Name:	Age:	Sex: Male / Female
Date of Birth:	Weight:	Height:
Address :		Phone #:

Needed Documentation: (in the past 90 days)

- ☐ History & Physical/Progress note
- ☐ Insurance
- ☐ Medlist
- ☐ PT order

Insurances Accepted (MediCal: not contracted)

- ☐ Medicare
- ☐ KOVA
- ☐ NBD (Network By Design)
- ☐ Cash Pay

Order:

☐ PT/OT to Eval and Treat (check one below)

- ☐ Custom Whelchair evaluation
- ☐ Durable Medical Equipment Evaluation

Medical Justificaton:

1) Length of Need: Lifetime unless specified
_____ Months or Lifetime (circle one)

2) Diagnosis: _____ DX Code: _____

3) Prognosis: Good Fair Poor (circle one)

Physician's Signature: Date:

NPI #

Physician's Name (Printed)

Address:

Phone # ( ) - Fax # ( ) -

"Helping Improve Our Patients' Quality of Life"

2230 W Sunnyside Ave Suite 1 Visalia , CA 93277
Office: 559.713.6461 | Fax: 559.713.6012 | Web: www.vaptpc.org | Group NPI: 1215655238