# DME STANDARD WRITTEN ORDER (SWO)

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|---|---|---|---|---|
| ***ORDER DATE:*** | | | Name of Practice / Facility: | |
| | | | Phone #: | |
| **PATIENT DEMOGRAPHICS** | | | | |
| ***FIRST NAME:*** | ***LAST NAME:*** | M.I. | ***PHONE:*** | |
| Street Address: | | City: | State: | Zip: |
| **DOB:** | Sex: M F | Ht: | Wt: | 2nd Contact/Phone: |
| **Primary Insurance:** ❑ Medicare ❑ Medicaid ❑ Other | | | **Secondary Insurance:** ❑ Medicare ❑ Medicaid ❑ Other | |
| Name: | | | Name: | |
| | | | | |
| Phone: | | | Phone: | |
| ***MBI/Policy #:*** | | | Policy #: | |

**SUPPORTING ICD-10 CODES**

| | | | |
|---|---|---|---|
| 1. | 2. | 3. | 4. |

*The patient named above is being treated under a comprehensive plan of care. I, the undersigned treating physician certify that the below prescribed is medically necessary for the patient. I believe that the following products are both reasonable and necessary for the overall patient's wellbeing, condition and/or rehabilitation. I certify that the patient's medical records reflect the need for the item ordered and will be sent to the DME provider along with this SWO.*

Please list the medical equipment to be provided below:

**SEAT LIFT MECHANISM (E0627)**

_____

_____

_____

_____

_____

_____

*QUANITY TO BE DISPENSED:* _____ *LENGTH OF NEED:* _____

| | | | |
|---|---|---|---|
| ***PHYSICIANS NAME:*** | | | ***NPI #:*** |
| Street Address: | City: | State: | Zip |
| Contact: | Phone: | Fax: | |

***PHYSICIANS SIGNATURE:*** _____ ***DATE:*** _____

**FAX this SWO to 704-821-7777 or email to [redacted]@mobility-more.com**

info