DME STANDARD WRITTEN ORDER (SWO)

ORDER DATE:			Name of Practice / Facility:	
Person completing this form:			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:	
Address:			Address:	
Phone:			Phone:	
MBI/Policy #:			Policy #:	

SUPPORTING ICD-10 CODES / NARRATIVE DIAGNOSIS

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.

❑ ***Standard Folding Walker***	❑ ***Hospital Bed***	❑ ***Adult Briefs / Pull Ups***	❑ ***Bedside Commode***
❑ ***Walker w/Wheels***	❑ ***Patient Lift***	❑ ***Under Pads / Gloves***	❑ ***Shower Chair***
❑ ***Rollator (walker w/wheels, seat & brakes)***	❑ ***Trapeze Bar***	❑ ***Wrist / Carpel Tunnel Brace***	❑ ***Transfer Bench***
❑ ***Transport Wheelchair***	❑ ***Gel Overlay***	❑ ***Ankle Brace Support***	❑ ***Raised Toilet Seat***
☑ ***Manual Wheelchair***	❑ ***Low Airloss Mattress***	❑ ***Back Brace Support***	❑ ***Breast Pump***
☑ ***Wheelchair Seat Cushion***	❑ ***Diabetic Shoes***	❑ ***Knee Brace Support***	❑ ***Urological Supplies***
☑ ***Wheelchair Back Cushion***	❑ ***Compression Stockings***	❑ ***Other:***	
❑ ***Motorized Wheelchair / Powerchair***	❑ ***Mobility Scooter / POV***	❑ ***Other:***	
☑ ***Elevating Leg Rest*** ☑ ***Adj. Ht. Armrest*** ☑ ***Seat Belt*** ☑ ***Heel Loops*** ☑ ***Brake Extensions*** ☑ ***Anti-Tippers***		***QUANITY TO BE DISPENSED:*** 1 ***LENGTH OF NEED:*** 99	
❑ ***Motorized Wheelchair / Scooter Repairs*** – repairs as needed to support continued patient's mobility needs in their home			

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

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

INFO

FAX this SWO to 704-821-7777 or email to ~~orders~~@mobility-more.com