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:	Social Security #:
Emergency Contact / Responsible Party:			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 / Underpads***	❑ ***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***	❑ ***Motorized Wheelchair / Scooter Repairs***	❑ ***Compression Hose***	❑ ***Medical Alarm***
❑ ***Motorized Wheelchair / Powerchair***	❑ ***Mobility Scooter / POV***	❑ ***Other:***	

❑ ***Elevating Leg Rest*** ❑ ***Anti-Tippers*** ❑ ***Seat Belt*** ❑ ***Heel Loops*** ❑ ***Brake Extensions*** ❑ ***OTHER:***	***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 info@mobility-more.com