FLORIDA MOBILITY
& MEDICAL PRODUCTS

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STANDARD WHEEL CHAIRS, POWER WHEEL CHAIRS, NEBULIZERS, BPAP, CPAP, SCOOTERS, RECLINING CHAIRS, COMMODES, CRUTCHES, WALKERS, ENTERAL, AND ALL ACCESSORIES.

DATE:_____

PT NAME: _____DOB:_____HT: _____WT: _____SEX: _____

HIC#_____POS_____DATE OF FACE TO FACE: _____

HCPCS CODE:_____,_____,_____,_____,_____,_____

ICD-9 CODE _____,_____,_____,_____,_____,_____

LENGTH OF NEED_____ MONTHS (99 = FOREVER)

DIAGNOSIS AND CONDITIONS THAT THE PRESCRIBED EQUIPMENT WILL MODIFY

_____

_____

_____

_____

DESCRIPTION OF THE ITEM_____

I CERTIFY THAT THE ABOVE PRESCRIBED EQUIPMENT/SUPPLIES IS MEDICALLY NECESSARY AS PART OF MY TREATMENT FOR _____. FOR ACCEPTED STANDARDS OF MEDICAL PRACTICE AND TREATMENT OF THE PATIENT'S CONDITION.

DR. SIGNATURE _____ DATE_____

PROVIDER UPIN # _____

PROVIDER NAME_____

ADDRESS _____

PHONE_____

COMMENTS:

THIS DOCUMENT MEETS THE MEDICARE REQUIREMENT FOR REPLACING THE CMN FOR ALL PMDs