FOOT WORK
DURABLE MEDICAL EQUIPMENT
A Pedorthic Center
7155 Hwy 90 W, San Antonio, Tx, 78227 (210) 678-0751 Fax (210) 678-0683

PRESCRIPTION & CERTIFYING STATEMENT FOR MEDICAL EQUIPMENT

Patient's Name: **Date of Birth:**

Address: **City:** **State:** **Zip:** **Phone:**

Medicare: **Medicaid/Secondary:** **Date:**

I am treating this patient under a comprehensive plan of care for his/her medical condition as per

ICD-9 Codes:

- [ ] Ulcer preventing Gel Cushion
- [ ] Positioning Wheelchair Cushion
- [ ] Positioning/ Ulcer Preventing Gel Cushion
- [ ] Alternating Pressure Mattress
- [ ] Gel Overlay Mattress
- [ ] Semi Automatic Hospital Bed
- [ ] Manual Wheelchair
- [ ] Lightweight manual Wheelchair
- [ ] Motorized Wheelchair
- [ ] Lymphedema Pump
- [ ] Trapeze
- [ ] Other:

Please note that form is not complete until required information is attached, such as face to face evaluation, CMN and progress notes. Please check the following for required forms to be added later.

- [ ] CMN
- [ ] Face to Face Evaluation
- [ ] Progress Notes

Due to the following (ICD - 9 Codes):

I understand by signing this form I have indicated the patient medical condition and the information listed above is accurate and correct. There is evidence of medical necessity documentation in the patient's chart that supports the need for the patient frequency of testing. The patient or a caregiver is able to use of the item i have prescribed.

Physician's Name: **Phone:**

Address: **Fax:**

City: **State:** **Zip Code:** **NPI:**

Physician's Signature: **Date:**

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