Lincare
Powered Mobility™

Thank you for choosing Lincare Powered Mobility to help you obtain a power mobility device. In order to do so, we will need your cooperation in assuring that your provider completes the required insurance documentation.

Enclosed please find a Mobility Evaluation Packet for you to bring with you at your scheduled mobility evaluation. You will need to let your provider know that you are there for a ***Power Mobility Exam***, and this must be indicated in your Medical Record/Chart Notes.

This is a time sensitive process and if we all work together, this can be achieved much sooner, and you may be placed with your NEW power mobility device in no time.

Please do not hesitate to contact me with any questions or concerns, at my information below. We thank you for your interest and look forward to being of service to you.

Sincerely,

Lincare Powered Mobility Team

If you have questions please call (866) 387-2668

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POWER MOBILITY EVALUATION

1.) Please complete the attached Written Order form at today's office visit

2.) Please complete the attached Power Mobility Device Evaluation form at today's office visit

3.) Please submit today's chart note documenting if the major reason for the visit was for a Power Mobility Device Evaluation and if the need for the Power Mobility Device is a medical neccessity for the patient to complete their in home Mobility Related ADL's

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Upon completion, please return **ALL THREE** documents to:

FAX: (855) 653-4197

Questions on the above request?

Call (866) 387-2668

Thank you for the assistance.

WRITTEN ORDER

1) **Patient's Name:** _____

2) **Encounter Date:** _____
(Order Date)

3) **Item for Order:** _____

4) **Option & Accessories:** **Quantity:**

- ■ Batteries 2
- ■ Oxygen Tank Carrier 1
- ■ Elevating Leg Rests, Pair 1
- ❒ Skin Protection Cushion _____
- ❒ Positioning Cushion _____

5) **ICD – 10's:** _____ _____ _____ _____

6) **Provider's NPI:** _____

7) **Provider's Name:** _____

8) **Provider's Signature:** _____
(NO Signature Stamps)

Based on my encounter with the patient on the above referenced date, it is my opinion that my patient needs this equipment for use inside the home in order to participate in one or more activities of daily living. I have determined that the equipment prescribed is the best-suited mobility device for my patient and my patient has the physical & mental abilities to operate the equipment.

POWER MOBILITY DEVICE EVALUATION

Evaluation Date: ___/ /

Patient Name: DOB:

Weight: ICD-10's: Past/Current Pressure Sores w/ Location:

1) Document at least one SPECIFIC Mobility Related ADL (MRADL) a Power Mobility Device will improve in the home: (i.e. mobilize to the restroom, mobilize to kitchen for meal prep, etc…)

2) When ordering a Scooter, specifically document ALL 3; if the patient can effectively operate the Tiller Steering System, Transfer On/Off independently and Maintain Postural Stability on a Scooter.

3) Please document why a Cane or Walker will not allow for in home MRADL's:

4) Please document why a Manual Wheelchair will not allow for in home MRADL's:

5) Is the patient able to Physically and Mentally operate the Power Mobility Device safely: YES NO

6) Strength: Upper: 5 *Normal* 4 *Good* 3 *Fair* 2 *Poor* 1 *Trace* 0 *None* Lower: 5 *Normal* 4 *Good* 3 *Fair* 2 *Poor* 1 *Trace* 0 *None*

7) ROM: Upper: 5 *Normal* 4 *Good* 3 *Fair* 2 *Poor* 1 *Trace* 0 *None* Lower: 5 *Normal* 4 *Good* 3 *Fair* 2 *Poor* 1 *Trace* 0 *None*

8) Pain: (Overall) 0 1 2 3 4 5 6 7 8 9 10

9) Projected Distance with Ambulation using a Cane or Walker: 0' 5' 10' 15' 20' No Limitations

10) Projected Distance with Self-Propulsion of a Manual Wheelchair: 0' 5' 10' 15' 20' No Limitations

ALL ADDITIONAL COMMENTS TO BE PLACED IN THE PATIENT'S MEDICAL RECORD

Ordering Provider Printed Name:

Ordering Provider Signature:

Date: