SSMHealth at Home

Power Mobility Device RX

Standard Written Order

DOB: _____

Patient Name: _____

Patient Address: _____

Order Date: _____

General description of the item, HCPCS code, a HCPCS code narrative, or a brand name/model number:

Quantity: _____

Provider Name (please print): _____

Provider Address: _____

Provider Signature: _____ Date: _____

NPI#: _____

Note: Medicare requires that <u>ALL</u> elements <u>MUST</u> be completed by the ordering provider and <u>MUST</u> be in the same provider's handwriting.

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