

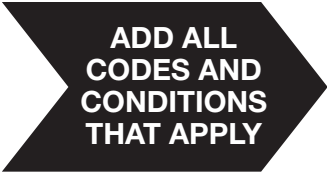
Power Mobility Device - 7 Element Order PRESCRIPTION

1. Beneficiary/Patient Name:  _____

2. Item for Order:  _____

3. Date of Face to Face Examination:  _____

4. Diagnosis/Condition Relating to the Need for Item:



ICD-9 Code	Diagnosis
_____ . _____	_____
_____ . _____	_____
_____ . _____	_____
_____ . _____	_____
_____ . _____	_____
_____ . _____	_____

5. Length of Need (LON):  _____ # of Months
(99=lifetime)

6. Physician's Signature:  _____
(No Signature Stamps)

7. Date:  _____