Detailed Product Description

Beneficiary Name ________________________________ **Medicare #** ________________________

Product Type ____________________________________ **DOB** ______________________________

Manufacture _____________________________________ **Model** ____________________________

Qty.	HCPCS Code	Product Description	Charge Amount	Medicare Allowable
1	K0823	Motorized Wheelchair	$2800.00	$2548.98
2	E0990	Elevating Leg-Rest, Each	$110.00	$99.61
2	E0973	Adjustable Height Armrest, Each	$125.00	$103.95
2	E2365	U-1 Gel Cell Batteries	$115.00	$101.41
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The signature below is to ensure that the physician is well informed about the equipment being provided to the patient and has the information necessary to provide feedback to the supplier as necessary about any safety or functional concerns. This form must be signed and dated by physician before product is delivered. You may fax this form to 704-821-1012. Any questions or comments, please call 704-821-7777.

Physician Signature ____ **Date** ________________________