



DME STANDARD WRITTEN ORDER (SWO)

ORDER DATE:		Name of Practice / Facility:			
Person completing this form:		Phone #:			
PATIENT DEMOGRAPHICS					
FIRST NAME:		LAST NAME:		M.I.	PHONE:
Street Address:			City:		State: Zip:
DOB:	Sex: M F	Ht:	Wt:	2 nd Contact/Phone:	
Primary Insurance: <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other			Secondary Insurance: <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other		
Name:			Name:		
Address:			Address:		
Phone:			Phone:		
MBI/Policy #:			Policy #:		
SUPPORTING ICD-10 CODES / NARRATIVE DIAGNOSIS					
1.	2.	3.	4.		
<p><i>The patient named above is being treated under a comprehensive plan of care. I, the undersigned treating physician certify that the below prescribed is medically necessary for the patient. I believe that the following products are both reasonable and necessary for the overall patient's wellbeing, condition and/or rehabilitation. I certify that the patient's medical records reflect the need for the item ordered and will be sent to the DME provider along with this SWO.</i></p>					
<input type="checkbox"/> Standard Folding Walker	<input type="checkbox"/> Hospital Bed	<input type="checkbox"/> Adult Briefs / Pull Ups	<input type="checkbox"/> Bedside Commode		
<input type="checkbox"/> Walker w/Wheels	<input type="checkbox"/> Patient Lift	<input type="checkbox"/> Under Pads / Gloves	<input type="checkbox"/> Shower Chair		
<input type="checkbox"/> Rollator (walker w/wheels, seat & brakes)	<input type="checkbox"/> Trapeze Bar	<input type="checkbox"/> Wrist / Carpel Tunnel Brace	<input type="checkbox"/> Transfer Bench		
<input type="checkbox"/> Transport Wheelchair	<input type="checkbox"/> Gel Overlay	<input type="checkbox"/> Ankle Brace Support	<input type="checkbox"/> Raised Toilet Seat		
<input type="checkbox"/> Manual Wheelchair	<input type="checkbox"/> Low Airloss Mattress	<input type="checkbox"/> Back Brace Support	<input type="checkbox"/> Breast Pump		
<input type="checkbox"/> Wheelchair Seat Cushion	<input type="checkbox"/> Diabetic Shoes	<input type="checkbox"/> Knee Brace Support	<input type="checkbox"/> Urological Supplies		
<input type="checkbox"/> Wheelchair Back Cushion	<input type="checkbox"/> Compression Stockings	<input type="checkbox"/> Other:			
<input type="checkbox"/> Motorized Wheelchair / Powerchair	<input type="checkbox"/> Mobility Scooter / POV	<input type="checkbox"/> Other:			
<input type="checkbox"/> Elevating Leg Rest <input type="checkbox"/> Adj. Ht. Armrest <input type="checkbox"/> Seat Belt		QUANTITY TO BE DISPENSED: _____			
<input type="checkbox"/> Heel Loops <input type="checkbox"/> Brake Extensions <input type="checkbox"/> Anti-Tippers		LENGTH OF NEED: _____			
<input type="checkbox"/> Motorized Wheelchair / Scooter Repairs – repairs as needed to support continued patient's mobility needs in their home					
PHYSICIANS NAME:				NPI #:	
Street Address:		City:		State:	Zip
Contact:		Phone:		Fax:	
PHYSICIANS SIGNATURE: _____				DATE: _____	

FAX this SWO to 704-821-7777 or email to orders@mobility-more.com