

FLORIDA MOBILITY & MEDICAL PRODUCTS

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STANDARD WHEEL CHAIRS, POWER WHEEL CHAIRS, NEBULIZERS, BPAP, CPAP, SCOOTERS, RECLINING CHAIRS,
COMMODOES, CRUTCHES, WALKERS, ENTERAL, AND ALL ACCESSORIES.

DATE: _____

PT NAME: _____ DOB: _____ HT: _____ WT: _____ SEX: _____

HIC# _____ POS _____ DATE OF FACE TO FACE: _____

HCPCS CODE: _____

ICD-9 CODE _____

LENGTH OF NEED _____ MONTHS (99 = FOREVER)

DIAGNOSIS AND CONDITIONS THAT THE PRESCRIBED EQUIPMENT WILL MODIFY

DESCRIPTION OF THE ITEM _____

I CERTIFY THAT THE ABOVE PRESCRIBED EQUIPMENT/SUPPLIES IS MEDICALLY NECESSARY AS PART OF MY
TREATMENT FOR _____. FOR ACCEPTED STANDARDS OF MEDICAL
PRACTICE AND TREATMENT OF THE PATIENT'S CONDITION.

DR. SIGNATURE _____

DATE _____

PROVIDER UPIN # _____

PROVIDER NAME _____

ADDRESS _____

PHONE _____

COMMENTS:

THIS DOCUMENT MEETS THE MEDICARE REQUIREMENT FOR REPLACING THE CMN FOR ALL PMDs