



Fax to Transcend Medical
256-259-1498 fax

Detailed Product Description for PMD

Patient Name: _____ DOB: _____ Length of Need: _____ (99Y=Lifetime)

Start Date: _____ Date of Face-to-Face Evaluation: _____ Diagnosis: _____

PMD (Power Wheelchair) Manufacturer Name/Model _____ HCPCS Code: K0821 or K0823

Narrative: Power Wheelchair, Group 2 Standard, Captain Chair, Patient Weight cap up to and including 300 lbs.

Accessories:

_____ Elevating Leg rest, complete assembly times two

Manufacturer Name/Model# :HCPCS: K0195 _____

Yes NO

- 1) Patient has a musculoskeletal condition or the presence of a cast which prevents 90 degree flexion of the knee or
- 2) Significant edema of lower extremities or
- 3) Reclining back wheelchair ordered

_____ Wheelchair Batteries U-1 batteries UI-B times two HCPCS Code: E2361 or E2365

Narrative: Power wheelchair accessory, U-1 sealed lead acid battery, each

_____ Skin Protection wheelchair seat cushion, adjustable, width less than 22 inches and depth

Manufacturer Name/Model#:HCPCS Code: E2601 _____

_____ Solid Seat Pan (Required for cushions)

Manufacturer Name/Model#:HCPCS Code: K0108 _____

_____ Description: _____ HCPCS Code: _____

Manufacturer Name/Model#: _____

Physician: _____ NPI #: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Physician Signature: _____ Date: _____ Fax: _____