

# AmeriHealth Mercy Wheelchair Fax Requisition Form



**MD Information**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Address 2: \_\_\_\_\_  
State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_  
Physician NPI: \_\_\_\_\_  
AmeriHealth Mercy ID #: \_\_\_\_\_

Date of Fax: \_\_\_\_\_

Patient Name: \_\_\_\_\_  
DOB: \_\_\_\_\_  
AmeriHealth Mercy ID #: \_\_\_\_\_  
Patient Address: \_\_\_\_\_  
Phone Number: \_\_\_\_\_  
Alternate Contact Name / Phone: \_\_\_\_\_

Patient Diagnosis: \_\_\_\_\_

ICD-9 Code	ICD-9 Description

**AVPU Scale / Level of Cognition:**

A+OX1     A+OX2     A+OX3     A+OX4     Alert / Not Oriented

Comments: \_\_\_\_\_

**Requested Equipment:**

Scooter / POV     Powered Wheelchair     Manual Wheelchair     Wheelchair Repairs     Wheelchair Modifications

Comments: \_\_\_\_\_

**Requested Accessories:**

Pressure Relief Cushion     Tilt-in-Space     Recline     Other: \_\_\_\_\_

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date