

# Medicare Qualification Form For Powered Wheelchairs

- Please fill in the requested information below and fax to 415-508-1083 or email to [daywalk@pacbell.net](mailto:daywalk@pacbell.net)
- We will contact your physician and send him/her the forms that need to be completed. These forms are necessary in order for Medicare to cover your wheelchair. You will also receive forms allowing us to bill your insurance company.
- We will contact you when all the forms are completed and send you information on the wheelchairs that Medicare will cover.
- Once all signed forms are received from you and your physician we will deliver your powered wheelchair.

## PERSONAL INFORMATION

First Name: \_\_\_\_\_

Middle Initial: \_\_\_\_\_

Last Name: \_\_\_\_\_

Mailing Address

Address 1: \_\_\_\_\_

Address 2: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Email Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

**PRIMARY INSURANCE INFORMATION**

Is Medicare your Primary Insurance? Yes \_\_\_\_\_ No \_\_\_\_\_

**If yes**, please enter your Medicare ID Number (**hint**: this is your social security number followed by a letter or number and is located on your red white and blue Medicare card)

Medicare ID Number: \_\_\_\_\_

**If no**, please fill in the following information on your insurance company.

Company Name: \_\_\_\_\_

Claims Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Group Number : \_\_\_\_\_

Policy Number: \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION**

If Medicare is your primary insurance **and you have a secondary insurance**, please fill in the section below.

Company Name: \_\_\_\_\_

Claims Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION (continued)**

Phone Number: \_\_\_\_\_

Group Number: \_\_\_\_\_

Policy Number: \_\_\_\_\_

**PHYSICIAN INFORMATION**

Doctors name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

**OTHER INFORMATION:**

Height: Ft. \_\_\_\_\_ Inches \_\_\_\_\_ Weight: \_\_\_\_\_ Lbs.

Date of Birth: \_\_\_\_\_