

Dear Doctor,

Please sign and date this prescription form and fax to Maxim Mobility at **203-772-0855** so that they may begin the proceedings to provide me with an appropriate wheelchair.

Thank you,

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**PRESCRIPTION FORM**

Date:

**PATIENT INFORMATION**

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

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

\_\_\_\_\_  
\_\_\_\_\_

Dear Doctor:

We have been asked to supply your patient with the following:

Wheelchair

Medicare/Medicaid requires that we obtain the information below. *If you believe that the equipment listed above is medically necessary*, please sign and date, then fax this form to Maxim Mobility at 203-772-0855. Thank you for your consideration.

Physician's Name:

Address:

Phone:

Fax:

**Doc Signature** \_\_\_\_\_

Date \_\_\_\_\_