

Wheelchair and Options/Accessories Certificate of Medical Necessity - Manual or Motorized

Recipient Name				Provider Name							
Recipient Address (current residence) City State Zip				Provider Address City State Zip							
Telephone number _____ Nursing facility?				Provider telephone number							
Recipient DOB	Sex	HT	WT	Provider identification number							
Recipient ID number				<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%; text-align: center;">HCPCS CODE(s)</td> <td style="width:50%; text-align: center;">DESCRIPTION</td> </tr> <tr> <td colspan="2" style="height: 100px;"> <hr/> </td> </tr> </table>				HCPCS CODE(s)	DESCRIPTION	<hr/>	
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<hr/>											
Physician Name											
Physician Address											
Telephone											

INFORMATION IN THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN, OCCUPATIONAL OR PHYSICAL THERAPIST

Estimated Length of Need (# of Months)	Diagnosis code (ICD-9)
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- Circle **Y** for Yes, **N** for No
1. Is a wheel chair appropriate for the patient to use to move around in their residence? Y N
 2. **Motorized Wheelchair base and ALL Accessories:**
 Does the patient have severe weakness of the upper extremities due to a neurologic, muscular or cardiopulmonary disease/condition? Y N
 Is the patient unable to operate any type of manual wheelchair? Y N
 Explain:
 Has the patient demonstrated ability to use a power wheelchair? Y N
 3. **Manual Wheelchair base and ALL Accessories:**
 Is the patient able to adequately self-propel (without being pushed) in a standard weight manual wheelchair? Y N
 If no, would the patient be able to adequately self-propel in the wheelchair which has been ordered? Y N
 Explain in detail:
 4. Can recipient ambulate?..... Y N
 5. Does the patient have quadriplegia, a fixed hip angle, a trunk case or brace, excessive extensor tone of the trunk. Y N
 muscles or a need to rest in a recumbent position two or more times during the day?
 Does the patient require frequent, significant adjustment of their position in the wheelchair to prevent skin breakdown? . . Y N _____Rolling Back
 6. Does the patient have a cast, brace or musculoskeletal condition, which prevents 90 flexion of the knee, or does. Y N _____Elevating Legrest
 the patient have significant edema of the lower extremities that requires an elevating legrest, or is a reclining back ordered?
 7. How many hours per day does the patient usually spend in the wheelchair? _____ (1 - 24, Round up to the next hour)
 8. Does the patient have the physical and mental ability to operate the requested wheelchair?Y N
 If no, explain in detail:
 9. Does the patient currently have a wheelchair?Y N Date of Purchase _____ Condition of wheelchair
 Type of wheelchair _____ List repairs and modifications within the last 6 months:

Name of person answering questions	Title Employer
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Narrative description of all items, accessories and options ordered; supplier s charge and any modifications requested. *Include medical necessity for each item.*
Additional information or justification for this request may be attached. THIS SECTION MUST BE COMPLETED.

Physician s signature	Date Signature and date stamps are not acceptable
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