Patient Information

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_Zip\_\_\_\_\_\_

Primary Insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Discharge Date\_\_\_\_\_\_\_\_\_\_\_\_ Height\_\_\_\_\_\_\_Weight\_\_\_\_\_\_Diagnonsis Codes\_\_\_\_\_\_\_\_\_\_\_\_\_Length of Need(# of Months)\_\_\_\_\_\_\_\_1-99 (99=Lifetime)

**MANUAL WHEELCHAIR STANDARD WRITTEN ORDER**

| **BASE EQUIPMENT: Select One - all basic chairs come w/standard footrests*** Wheelchair, Standard (K0001), 250lb max
* Wheelchair, Hemi Height (K0002), 250lb max
* Wheelchair, Light Weight (K0003), 250lb max
* Wheelchair, High Strength, Light Weight (K0004), 250lb max
* Wheelchair, HD (K0006), 300lb max
* Wheelchair Extra HD (K0007), 450lb max
 | **ACCESSORIES*** Anti-tippers
* Back Cushion
* Seat Cushion
* Seat Belt
* Elevating Leg Rests
* Brake Extensions
* Transfer Board
* Reclining Back
* Heel Loops
* Arm Supports
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MEDICAL NECESSITY INFORMATION: Must also be supported in the medical records, if applicable.

1. Does the patient have a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADL) in the home? \_\_\_\_YES\_\_\_\_NO
2. Can the patient's mobility limitation be sufficiently resolved by the use of an appropriately fitted cane or walker? \_\_\_\_YES\_\_\_\_NO
3. Does the patient's home provide adequate access between rooms, maneuvering space, and surfaces for use of the manual wheelchair that is ordered? \_\_\_\_YES\_\_\_\_NO
4. Will the use of a manual wheelchair significantly improve the patient's ability to participate in MRADLs and will the patient use it on a regular basis in the home? \_\_\_\_YES\_\_\_\_NO
5. Does the patient have sufficient upper extremity function and other physical & mental capabilities needed to safely self-propel the manual wheelchair? \_\_\_\_YES\_\_\_\_NO
6. If the patient is unable to propel the wheelchair ordered, is there a caregiver available and willing to provide assistance with the wheelchair? \_\_\_\_YES\_\_\_\_NO
7. If a hemi height wheelchair is ordered: Does the patient require a lower seat height (17" to 18") because of short stature or to enable the patient to place feet on the ground for propulsion? \_\_\_\_YES\_\_\_\_NO
8. \*If a lightweight wheelchair is being ordered: Can the patient self-propel in a standard weight wheelchair? \_\_\_\_YES\_\_\_\_NO
9. \*If a lightweight wheelchair is being ordered: Can and will the patient self-propel in a light weight wheelchair? \_\_\_\_YES\_\_\_\_NO
10. \*If a high strength lightweight wheelchair is being ordered: Does the patient self-propel the wheelchair while engaging in frequent activities in the home that cannot be performed in a standard or lightweight wheelchair? \_\_\_\_YES\_\_\_\_NO
11. \*If a high strength lightweight wheelchair is being ordered: Does the patient require a seat width, depth, or height that cannot be accommodated in a standard, lightweight, or hemi-wheelchair, and spends at least two hours per day in the wheelchair? \_\_\_\_YES\_\_\_\_NO

| PROVIDER CERTIFICATION: *I, the patient's treating provider, certify the medical necessity of these items for this patient and maintain medical records reflecting the medical justification and care provided.*Provider Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_NPI:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Provider Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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