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

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|---|---|---|---|---|
| Client Name | | | | Provider Name |
| Client Address (Current Residence)<br>City State Zip<br>Telephone number _____ Nursing facility? | | | | Provider Address<br>City State Zip<br>Provide r telephone number |
| Client DOB | Sex | HT WT | | Provider identification number |
| Client ID number | | | | HCPCS CODE(s) DESCRIPTION |
| Physician Name | | | | |
| Physician Address | | | | |
| Telephone | | | | |
| | | | | _____ |

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

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|---|---|---|
| Estimated Length of Need (# of Months) | | Diagnosis code (ICD-10) |

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 Leg rest
   the patient have significant edema of the lower extremities that requires an elevating leg rest, 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 |

**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 dated stamped and Electronic signatures are not acceptable.)** |