847-824-0500 * PULMONARY PROVIDERS GROUP, INC. * 847-824-0529 fax

CERTIFICATE OF MEDICAL NECESSITY

Standard Wheelchair Order Form

Referral Source:_____ Referral Source Phone:(_____)_____

PATIENT INFORMATION

Last Name:_____ First Name:_____

Address: _____

City:_____ State: Illinois Zip code:_____

Phone Number: (_____)_____

Sex: Female_____ Male_____ Birth Date:_____/_____/_____

Height:_____ Weight:_____ Required

DIAGNOSIS INFORMATION

Primary :_____

Secondary:_____

INSURANCE INFORMATION

Medicaid Recipient Number:_____

Managed Care Medicaid Name:_____ Policy:_____

Private Insurance Name:_____ Policy:_____

PRODUCT(S) REQUESTED

[ ] **Standard Wheelchair - K0001;** [ ] **Elevating Legrest;** [ ] **Other:**_____

A manual wheelchair for use inside the home is covered if: Criteria A, B, C, D, and E are met; and • Criterion F or G is met.

A. The beneficiary has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADLs) such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home. A mobility limitation is one that:

1. Prevents the beneficiary from accomplishing an MRADL entirely, or
2. Places the beneficiary at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL; or
3. Prevents the beneficiary from completing an MRADL within a reasonable time frame.

B. The beneficiary's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker.

C. The beneficiary's home provides adequate access between rooms, maneuvering space, and surfaces for use of the manual wheelchair that is provided.

D. Use of a manual wheelchair will significantly improve the beneficiary's ability to participate in MRADLs and the beneficiary will use it on a regular basis in the home.

E. The beneficiary has not expressed an unwillingness to use the manual wheelchair that is provided in the home.

F. The beneficiary has sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the manual wheelchair that is provided in the home during a typical day. Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity absence of one or both upper extremities are relevant to the assessment of upper extremity function.

G. The beneficiary has a caregiver who is available, willing, and able to provide assistance with the wheelchair.

Length of Need_____ (1-99months) 99=lifetime

PHYICIAN INFORMATION

Print Name:_____

Address:_____

City:_____ State:_____ Zip code:_____

Phone Number:(_____)_____

NPI:_____

I, the undersigned, certify that the above prescribed Durable Medical Equipment/Supplies are medically necessary as a part of my treatment for this patient. In my opinion, the equipment/item(s) prescribed are reasonable and necessary for the accepted standards of medical practice and treatment in patient's condition.

Physician Signature:_____ Date:_____/_____/_____