



Wheelchair Medical Necessity and Home Evaluation Verification

For Manual Wheelchair (MWC) and POVs (i.e., Power Wheelchair, Scooter, Other Power-operated Vehicle)

See Medical Policy DME101.010, Wheelchairs and Accessories

Contact person: (please print) Phone #

Physical Therapist Fax #

Group # Patient Name

Subscriber # Subscriber Name

Referral # (if applicable) Address (street) (city) (state) (zip)

Please complete all the questions fully. Failure to do so will result in delay or possible denial of claims.

Patient Age Sex: Male Female Height Weight

Primary Diagnosis Date Duration?

Secondary Diagnosis Date Duration?

Date you examined the patient and attested to the letter of medical necessity

What are the change(s) in your patient's medical condition that now impairs his/her mobility?

Until now, what has been your patient's mode of mobility in the home?

Is the patient able to safely operate a MWC?

If NOT, why not?

Is the patient able to safely operate and control a POV?

Location where MWC or POV will primarily be used?

Is the patient's duration of need greater than 6 months?

Can the patient safely transfer in and out of a POV?

Does the patient have adequate trunk control to safely ride in a POV?

List activities for which equipment is primarily to be used:



What wheelchair accessories do you anticipate this patient needing, and why? _____

Will the MWC or POV fit through the doorways into and inside of the home? _____

Does the physical layout of the home allow unhindered use of the MWC or POV? _____

Are there any surfaces or obstacles inside the home that may render the MWC or POV unusable in the home? _____

The patient's home should provide adequate access, maneuvering space, and surfaces, as well as prevailing temperature and physical layout, for the safe operation of the MWC or POV. Overall, is the home environment conducive both to getting the MWC or POV into the home and to safe operation within the home? _____

Are the patient's physical and mental capabilities adequate and appropriate for the device requested? - _____

Is the patient motivated and willing to use the device routinely? _____

The provider attests that the patient and the home have been evaluated, that the equipment requested is medically necessary and appropriate for the patient, that the home environment is conducive to the safe and successful operation of the device, and that this questionnaire has been answered honestly and accurately.

Signature: _____ Date: _____

National Provider Identifier (NPI) Number(s): _____

Provider's Name Printed: _____

Provider's Signature: _____

Phone Number: _____ **Date:** _____