℞ CLARIFICATION OF WRITTEN ORDER AND MEDICAL JUSTIFICATION
WHEELCHAIR

Date of Last Provider Visit_____

Supplier Name, Address, Telephone & NSC#:	**Patient Name, Address, Telephone & HIC#:**
PROCARE HOME MEDICAL **713 Northway Dr.** **Anchorage, AK 99508** **Phone: (907) 274-0770** **Fax: (907) 274-0773** **NSC#: 1267160001**	**( ) - HIC#:** **Patient DOB: / / Sex: (M/F)**

An order was received on _____ for the services/equipment provided to the above named patient. In order to properly bill for the services/equipment provided we require a revised detailed written order. Please review and verify this information by completing any of the highlighted areas, and date and sign at the bottom. We suggest you keep a copy of this for your records. Prepared by:_____

WHEELCHAIR & FRONT RIGGING:

Date of Service: _____

Diagnosis and Code: _____

Length of Need (# of months): _____1-99 (99=life)

Patient Height: _____ft. in. Weight: _____ lbs.

Equipment:

- ☐ Wheelchair, Standard, 250lb (K0001)
- ☐ Wheelchair, Hemi Height, 250 lb (K0002)
  Note: Seat to floor height is approximately 17"
- ☐ Wheelchair, Light Weight, 250 lb (K0003/K0004)
  Note: W/C weighs approximately 34lbs
- ☐ Wheelchair, HD, 250-299 lb (K0006)
- ☐ Wheelchair, Extra HD, 300-450 lb (K0007)
- ☐ Wheelchair, Pediatric (E1236)
- ☐ Other:_____

Front Rigging:

- ☐ Footrest, Standard
- ☐ Elevating Leg Rest, Standard (K0195)
- ☐ Elevating Leg Rest, Telescoping (K0053)
  Note: Telescoping ELR's are used for tall patients (6'2") and specialty casts.

Optional Equipment:

- ☐ Cushion, Basic (Wheelchair) (E2601/E2602)
- ☐ Anti-Tipper (E0971)
- ☐ Seat Belt, Velcro (E0978)
- ☐ Brake Extensions (E0961)

MEDICAL NECESSITY INFORMATION:

REQUIRED CRITERIA

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?
   ☐ Y ☐ N
2. Can the patient's mobility limitation be sufficiently resolved by the use of an appropriately fitted cane or walker?
   ☐ Y ☐ N
3. Does the patient's home provide adequate access between rooms, maneuvering space, and surfaces for use of the manual wheelchair that is ordered?
   ☐ Y ☐ N
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?
   ☐ Y ☐ N
5. Does the patient have sufficient upper extremity function and other physical & mental capabilities needed to safely self-propel the manual wheelchair?
   ☐ Y ☐ N
6. If the patient is unable to propel the wheelchair ordered, is there a caregiver available & willing to provide assistance with the wheelchair?
   ☐ Y ☐ N ☐ N/A

If hemi height wheelchair is ordered:

7. Does the patient require a lower seat height (17" to 18") because of short stature or to enable patient to place feet on the ground for propulsion?
   ☐ Y ☐ N ☐ N/A

If lightweight wheelchair is ordered:

8. Can the patient self-propel in a standard weight wheelchair?
   ☐ Y ☐ N
9. Can the patient self-propel in a lightweight wheelchair?
   ☐ Y ☐ N

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's Signature Date

_____

Provider's Name

NPI: _____ Telephone: _____