℞ WRITTEN ORDER AND MEDICAL JUSTIFICATION
WHEELCHAIR

Date of Last Provider Visit_____

Supplier Name, Address, Telephone & NSC#:	**Patient Name, Address, Telephone & Insurance ID #:**
PROCARE HOME MEDICAL **4215 Credit Union Dr.** **Anchorage, AK 99503** **Phone: (907) 274-0770** **Fax: (907) 274-0773** **NSC#: 1267160001**	**( ) - Ins ID#:** **Patient DOB: / / Sex: (M/F)**

We have been asked to provide the following equipment to the patient named above. 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.

WHEELCHAIR & FRONT RIGGING:

Diagnosis and Code: _____

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

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

Equipment:

- ☐ Wheelchair, Standard, 250lb max (K0001)
- ☐ Wheelchair, Hemi Height, 250 lb max (K0002)
  Note: Seat to floor height is approximately 17"
- ☐ Wheelchair, Light Weight, 250 lb max(K0003/K0004)
  Note: W/C weighs approximately 34lbs
- ☐ Wheelchair, HD, 300lb max (K0006)
- ☐ Wheelchair, Extra HD, 450lb max (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 (E2601/E2602)
- ☐ Anti-Tipper (E0971)
- ☐ Seat Belt, Velcro (E0978)
- ☐ Brake Extensions (E0961)
- ☐ Basic Back (E2611)
- ☐ Transfer Board (E0705) 400lb max
- ☐ Reclining Back (E1225)
- ☐ 02 Holder

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: _____