℞ WRITTEN ORDER AND MEDICAL JUSTIFICATION
WHEELCHAIR

Supplier Name, Address, Telephone & NSC#:	**Patient Name, Address, Telephone & Insurance ID#:**
PROCARE HOME MEDICAL 915 30th Avenue Fairbanks, AK 99701 Phone: (907) 458-8912 Fax: (907) 458-8914 NSC#: 1267160002	**( ) - Ins ID#:** **Patient DOB: / / Sex: (M/F)**

Please fax orders along with required documentation to **(907)** 458-8914 or email to **dme**@procarehm.com.

Diagnosis and Code _____

Length of Need (# of months): _____ 1-99 (99=life)

Patient Height: _____ ft. in.

Patient Weight: _____ lbs.

BASE EQUIPMENT: *Select One*

- ☐ Wheelchair, Standard (K0001), 250lb max
- ☐ Wheelchair, Hemi Height (K0002), 250lb max
- ☐ Wheelchair, Light Weight (K0003/K0004), 250lb max
- ☐ Wheelchair, HD (K0006), 300lb max
- ☐ Wheelchair Extra HD (K0007), 450lb max
- ☐ Wheelchair, Pediatric (E1236/E1238)
- ☐ Other: _____

OPTIONS:

- ☐ Footrest, Swing Away
- ☐ Elevating Leg Rests, Standard (K0195)
- ☐ Elevating Leg Rests, Telescoping (K0053)
  Note: Telescoping ELR's are used for tall patients (6'2") and speciality casts
- ☐ Brake Extensions (E0961)
- ☐ Transfer Board (E0705)
- ☐ Reclining Back (E1225)
- ☐ Oxygen Tank Holder

STANDARD SAFETY PACKAGE: *Select One*

- ☐ Anti-tippers, right & left (E0971), Basic Back Cushion (E2611), Basic Cushion (E2601/E2602), Seat Belt (E0978)

MEDICAL NECESSITY INFORMATION: *Must also be supported in the medical records, if applicable.*

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 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 and willing to provide assistance with the wheelchair? ☐ Y ☐ N

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

If lightweight wheelchair is being ordered:

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

If high strength lightweight wheelchair is being ordered:

10. Does the patient self-propel the wheelchair while engaging in frequent activities in the home that cannot be performed in a standard or lightweight wheelchair? ☐ Y ☐ N
11. Does the patient require a seat width, depth, or height that cannot be accommodated in a standard, lightweight, or hemi-wheelchair, and spends at least two hours per day in the 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: _____ NPI: _____

Provider's Name: _____ Telephone: _____