

Certificate of Medical Necessity Form



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Manual Wheelchair

SECTION 1: CERTIFICATION DATE: INITIAL ____/____/____ REVISED ____/____/____

Patient Name _____
Printed or Typed

Address _____
Street

City State ZIP Code County

Telephone (____) ____ - _____ ID# _____

Supplier Name _____
Printed or Typed

Address _____
Street

City State ZIP Code County

Telephone (____) ____ - _____ NPI# _____

Physician Name _____
Printed or Typed

Address _____
Street

City State ZIP Code County

Telephone (____) ____ - _____ ID# _____

PT DOB ____/____/____ SEX ____ (M/F); HT ____ (IN.); WT. ____ (LBS)

Section 1

SECTION 2: MEDICAL NECESSITY INFORMATION (Physician if this section is blank please complete)

Estimated length of need (# of months): _____
1 through 99 (99 = lifetime)

Diagnosis codes (ICD-9): _____ - _____/
_____ - _____/ _____ - _____/
_____ - _____/ _____ - _____/

Section 2

- YES NO Is the patient's condition such that without the use of a wheelchair, he/she would otherwise be bed or chair confined?
- YES NO Is the patient able to ambulate with crutches or walker?
- YES NO Does the patient have quadriplegia, a fixed hip angle, a trunk cast or brace, excessive extensor tone of the trunk muscles or a need to rest in a recumbent position two or more times during the day?
- YES NO Does the patient have a cast, brace or musculoskeletal condition, which prevents 90-degree flexion of the knee, or does the patient have significant edema of the lower extremities that requires an elevating leg-rest or is reclining back ordered?
- YES NO Does the patient have a need for arm height different than those available using non-adjustable arms?

What percent of the day does the patient usually spend in the wheelchair? _____

Itemization of items and charges for each. (Attach additional sheet if necessary.) _____

Section 3

SECTION 3: PHYSICIAN ATTESTATION AND SIGNATURE/DATE

I certify that I am the physician identified in Section A of this form. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge. (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

Physician's Signature _____

Date ____/____/____