

Certificate of Medical Necessity Form



www.bcbsks.com

Motorized 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 (_____) _____ - _____ NPI# _____

PT DOB ____/____/____ SEX _____ (M/F) HEIGHT _____ WEIGHT _____

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): _____ - _____ /
_____ - _____ / _____ - _____ /
_____ - _____ / _____ - _____ /

- YES NO Does the patient require use of a motorized wheelchair to move around in their residence?
- YES NO Have all types of manual wheelchairs (including lightweights) been considered and ruled out?
- YES NO Does the patient require a motorized wheelchair only for movement outside of their residence?
- YES NO Is the physician signing this form a specialist in physical medicine, orthopedic surgery, neurology or rheumatology?
- YES NO Is the patient more than one day's round trip from a specialist in physical medicine, orthopedic surgery, neurology, or rheumatology?
- YES NO Does the patient's physical condition prevent a visit to a specialist in physical medicine, orthopedic surgery, neurology, or rheumatology?

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 2

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 _____ / _____ / _____

Section 3