

Certificate of Medical Necessity Form



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Power Operated Vehicle (POV)

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

Section 2

- YES NO Does the patient require use of a POV 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 POV 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?

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)

Section 3

Physician's Signature

Date _____ / _____ / _____