Certificate of Medical Necessity

Form for manual wheelchair

Section 1A – Patient Information

First Name ____ MI ____ Address ____

Last Name ____ Suffix ____ City ____

Phone Number ____ ID Number ____ State ____ ZIP Code ____ +4 ____ County ____

Date of Birth ____ Height ____ Weight ____

Section 1B – Supplier Information

Supplier Name ____ Address ____

Phone Number ____ NPI Number ____ City ____

State ____ ZIP Code ____ +4 ____ County ____

Section 1C – Physician Information

First Name ____ MI ____ Address ____

Last Name ____ Suffix ____ City ____

Phone Number ____ ID Number ____ State ____ ZIP Code ____ +4 ____ County ____

Section 2 – Medical Necessity Information

Note: Physician, if this section is blank, please complete.

Initial Certification Date ____ Revised Certification Date ____

Estimated length of need (number of months) ____
1 – 99 (99 = Lifetime)

Diagnosis codes (ICD-10) – separate with a comma:

____

____

____

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

____

Yes	No	
☐	☐	Is the patient's condition such that without the use of a wheelchair, he/she would otherwise be bed or chair confined?
☐	☐	Is the patient able to ambulate with crutches or walker?
☐	☐	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?
☐	☐	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?
☐	☐	Does the patient have a need for arm height different than those available using non-adjustable arms?

Please continue on the next page.

Section 2 – Medical Necessity Information

Itemization of items and charges for each (attach an additional sheet if necessary):

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Section 3 – Physician Attestation and Signature

I certify that I am the physician identified in section 1C of this form. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge.

Your signature required

____ ____ ____ ______

Physician's Signature (Signature and date stamps are not acceptable) Date Signed