Certificate of Medical Necessity

Form for power operated vehicle (POV)

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:

____

____

____

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

Please continue on the next page.

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