

CERTIFICATE OF MEDICAL NECESSITY

MOTORIZED WHEELCHAIRS

SECTION A Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER (____)____-____-____ HICN _____		SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER (____)____-____-____ NSC # _____	
PLACE OF SERVICE _____ NAME and ADDRESS of FACILITY if applicable (See Reverse)	HCPCS CODE _____ _____ _____	PT DOB ___/___/___; Sex ___ (M/F); HT. ___(in.); WT. ___(lbs.) PHYSICIAN NAME, ADDRESS, TELEPHONE and UPIN NUMBER (____)____-____-____ UPIN # _____	

SECTION B Information in This Section May Not Be Completed by the Supplier of the Items/Supplies.

EST. LENGTH OF NEED (# OF MONTHS): _____ 1-99 (99=LIFETIME)		DIAGNOSIS CODES (ICD-9): _____	
ITEM ADDRESSED	ANSWERS	ANSWER QUESTIONS 1, 6 AND 7 FOR MOTORIZED WHEELCHAIR BASE, 1-5 FOR WHEELCHAIR OPTIONS/ACCESSORIES. (Circle Y for Yes, N for No, or D for Does Not Apply, unless otherwise noted.)	
Motorized Whlchr Base and <u>All Accessories</u>	Y N D	1. Does the patient require and use a wheelchair to move around in their residence?	
Reclining Back	Y N D	2. 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?	
Elevating Legrest	Y N D	3. 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 legrest, or is a reclining back ordered?	
Adjustable Height Armrest	Y N D	4. Does the patient have a need for arm height different than that available using non-adjustable arms?	
Reclining Back; Adjustable Height Armrest	_____	5. How many hours per day does the patient usually spend in the wheelchair? (1-24) (Round up to the next hour)	
Motorized Whlchr Base	Y N D	6. Does the patient have severe weakness of the upper extremities due to a neurologic, muscular, or cardiopulmonary disease/condition?	
Motorized Whlchr Base	Y N D	7. Is the patient unable to operate any type of manual wheelchair?	

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):
 NAME: _____ TITLE: _____ EMPLOYER: _____

SECTION C Narrative Description of Equipment and Cost

(1) Narrative description of all items, accessories and options ordered; (2) Supplier's charge; and (3) Medicare Fee Schedule Allowance for each item, accessory, and option. (See *instructions on back*.) If additional space is needed, list wheelchair base and most costly options/accessories on this page and continue on HCFA Form 854.

CHECK HERE IF ADDITIONAL OPTIONS/ACCESSORIES ARE LISTED ON ATTACHED HCFA FORM 854

SECTION D Physician Attestation and Signature/Date

I certify that I am the treating physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE _____ DATE ___/___/___ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)