

## (1) Medical Necessity for Wheelchair Purchase (for home clients only)

Fax number: 1-866-668-1214

**NOTE:** The small numbers coordinate with the instructions. **Do not alter this form in any way.** 

(2) All spaces MUST be completed within 60 days of request including signature of person completing the section and date completed.

(2) SECTION 1 – The vendor may complete information in this section.								
Client name			Client ID		(3) RX on file Yes No			
Physician/therapist name	,		Fax number					
(4) Lower leg length (inches)	(4) Upper leg length (inch	4) Upper leg length (inches) (4) Hip v		vidth measurement (inches)				
Does client currently own a wheelchair? Yes No	If yes, Manual Pov		Purchased by Priva	te Donated		Date purchased		
Approximate age	Make		Model number		Serial number			
Physician, therapist or vendor signature			Date					
(2) SECTION 2 – This section may only be completed by the physician or therapist.								
(5) Diagnosis/Specific/Disabilities as applies to requested equipment including relevant degree of contractures.								
(6) Indicate if applicable  Scoliosis Kyphosis Degree of curvature			Patient height (INCHES)		Patient weight (LBS)			
Will equipment be needed approximately six months or less?  No								
Will the requested equipment meet the If no, please explain:	e client's l	ong term needs?   Yes	□ No					
Will the client use the wheelchair every If no, please explain:	y day? If y	res, how many hours per d	ay?					

Name	Client pic						
If manual wheelchair, can the client effectively and independently propel	the wheelchair?  Yes  No						
If yes, number of feet propelled at one time in the requested_wheelchair:	— —						
Does client propel with: arms feet both							
If yes, distance in feet at one time:							
If a power wheelchair is requested, tell us why the client is unable to operate a manual wheelchair.							
is a power wheelenan is requested, ten as why the energical anable to operate a manual wheelenan.							
NACII abo waa waa ad wala alaba iy fia into the aliant/a baysa 2 / Dlagas iyaliyda b	allows hadrons and bathroom \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \						
Will the requested wheelchair fit into the client's home? (Please include hallway, bedroom, and bathroom).   Yes  No  If no, please explain.							
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Does the client's home have a ramp?  Yes No							
If no, are plans in process to have one built? Yes No							
Can the requested wheelchair be transported in the vehicle? Yes	7 No						
School Bus Yes No							
Is there public transportation available in the community?  Yes  No							
Indicate client specific medical justification for each of the following: (Ph							
<b>Recommendations</b> : If you are unsure of the client's specific wheelchair needs, including make/model of wheelchair and all accessories and modifications, refer the client to a physical/occupational therapist for a complete wheelchair evaluation.							
(7) Make and model of equipment	ompiete wheelchair evaluation.						
(i) make and model of equipment							
(7 A-F) All Accessories and Modifications: (You may submit additional attachments)							
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(8) If the client's current wheelchair does not meet the medical need, w	not?						
(2) Physician's signature	Date						
(2) r nysician s signature	Date						
(2) Therapist's signature	Date						
	hat the medical necessity information in Section 2 is true, accurate, and						
	n, omission, or concealment of material fact in those sections may subject						
me to civil or criminal liability.							

## **INSTRUCTIONS**

- 1. This form is for all HCA clients requiring a wheelchair purchased for their use.
- 2. All spaces must be completed, signed and date within 60 days of HCA receiving request. Form has been split into two sections. Section 1 may be completed by the vendor or can be completed by the doctor or therapist. Section 2 may only be completed by the doctor or therapist.
- 3. RX on file means: The vendor must have a physician's prescription in the client's file for any new equipment or new accessories on existing equipment due to a change in medical condition.
- 4. Please indicate all measurements in inches. Lower leg length is measured from the popliteal crease to base of heel. Upper leg length is measured from back of buttocks to popliteal crease. Hip measurement is measured from hip tissue.
- 5. Only list those diagnoses and disabilities that apply to the equipment being requested.
- 6. If a custom back or wheelchair with tilt in space or recline feature is being requested, the information regarding Scoliosis and Kyphosis must be completed.
- 7. The make/model of wheelchair and each accessory/modification requested must be justified separately. You may use the lines on the physical therapy evaluation form or you may submit an additional attachment listing each item and the medical necessity for them.

When justifying the equipment and accessories the following information is necessary.

- A. Indicate what other less expensive alternatives have been tried or considered and why they will not meet the client's medical needs.
- B. All justifications must be client specific General statements as to standards of care or industrial standards for generalized equipment use are not appropriate to justify specific equipment needs.
- C. When requesting a specialized back or a wheelchair with a tilt-in-space or recline feature, indicate the degree of curvature requiring the modification (e.g. Scoliosis, Kyphosis or Lordosis).
- D. Indicate if the client has excessive extensor tone/muscle spasticity of the trunk/upper body muscles requiring support or impacting the degree of hip flexion/extension.
- E. For specialized cushions, indicate what other cushions have been tried, what the documented outcome was and the length of trial or what other cushions were considered and why they will not meet the client's medical needs. Also document if client has an existing decubitus and if so what the stage is. If the client has a history of decubitus, indicate dates, stage, site and duration.
- F. Indicate if the client has any musculoskeletal conditions, cast or brace that prevents 90-degree flexion of the knee or hip.
- 8. If client already owns a wheelchair, and a new wheelchair is being requested, indicate the medical reasons the existing wheelchair no longer meets the client's needs. Indicate if it can be repaired or modified to meet the client's needs and if not, why not. If the chair can be repaired or modified to meet the client's needs, the vendor supplying the equipment will need to submit a cost comparison for repairs vs. purchase.