MANUAL WHEELCHAIR (weight less than 250 lbs)

Physician Written Order Prior to Delivery / Certificate of Medical Necessity

HOME MEDICAL INC

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Order Date _____ **Length of Need** _____ Patient last seen _____ Discharge Date _____

PATIENT INFORMATION:

Name _____ DOB _____

Address _____ City _____ State _____ Zip _____

Phone _____ Height _____ Weight _____ Seated Hip Measurement _____

Medicare / Insurance Number _____ **ICD 10 Codes** _____ Prognosis _____

MANUAL WHEELCHAIR (Weight less than 250 lbs) (K0001, QTY:1)

With: ❍ **Anti-Tipping Device** (E0971, QTY:2)* ❍ **Heel Loop** (E0951, QTY:2)* ❍ **Brake Handle Extensions** (E0961, QTY:2)*

**If selected please include additional medical documentation of medical necessity*

Medical records documenting a face to face evaluation that the item is "reasonable and necessary" using the following criteria must be attached:

1. Beneficiary has a mobility limitation that significantly impairs his/her ability to participate in 1 or more mobility related activities such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home
2. Beneficiary's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker
3. Beneficiary's home provides adequate access between rooms, maneuvering space, surfaces for use of the manual wheelchair
4. Use of a manual wheelchair will significantly improve the beneficiary's ability to participate in MRADLs and will be used on a regular basis in the home
5. Beneficiary has not expressed an unwillingness to use the manual wheelchair that is provided in the home
6. Beneficiary has a caregiver who is available, willing, and able to provide assistance with the wheelchair

OR

7. The beneficiary has sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the manual wheelchair that is provided in the home during a typical day.

Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function.

❍ **Back Support Cushion** – General Use (E2611, Qty: 1)

❍ **Seat Cushion** – General Use (E2601, E2603 - Skin Protection, Qty: 1)

Cushion Selection Is Based On The Qualifying Diagnosis Below (See ICD-10 Diagnosis Codes On Back)

COMPLETE THE DIAGNOSIS CODES BELOW

G20. _____ **Parkinson's**	**G35.** _____ **Multiple Sclerosis**	**G81.** _____ **Hemiplegia**	**G82** _____ **Paraplegia**
G30. _____ **Alzheimer's**	**G71.** _____ **Muscular Dystrophy**	**G82.** _____ **Quadriplegia**	**L89.** _____ **Pressure Ulcer**

Other: _____

If no valid diagnosis code is provided a E2601 general use cushion will be delivered

❍ **Wheelchair Elevating Leg Rest / Articulating Leg Rest** (K0195/K0053)

Indicate which of the following conditions describe the patient. Check all that apply.

❍ Patient has a musculoskeletal condition or the presence of a cast or brace which prevents 90 degree flexion at the knee

❍ Patient has significant edema of the lower extremities that requires having an elevating leg rest

❍ Patient meets the criteria for and has a reclining back on the wheelchair

I, the undersigned, certify that the above prescribed equipment/supplies is medically necessary as part of my treatment for this patient, In my opinion, the equipment prescribed is reasonable and necessary for accepted standards of medical practice and treatment of this patient's condition and has not been prescribed as "convenience equipment".

Physician Name _____ Physician Phone # _____

Physician Address _____ City _____ State _____ Zip _____

Physician Signature _____ NPI# _____ Date _____

Note: Please maintain a copy of the WRITTEN ORDER, which must be kept on file for 7 years or longer if required by state law.