OHIO DEPARTMENT OF JOB AND FAMILY SERVICES
LETTER OF MEDICAL NECESSITY
FOR
MANUAL WHEELCHAIRS
WITHOUT CUSTOM SEATING

THIS FORM MAY BE COMPLETED BY A PHYSICIAN, LICENSED PHYSICAL THERAPIST OR LICENSED OCCUPATIONAL THERAPIST AND MUST BE SUBMITTED WITH THE PRIOR AUTHORIZATION REQUEST FOR STANDARD WEIGHT, LIGHTWEIGHT, HIGH STRENGTH LIGHTWEIGHT, ULTRA LIGHTWEIGHT, OR HEAVY DUTY WHEELCHAIRS OR MAINTAINED ON FILE FOR RENTAL WHEELCHAIRS ELIGIBLE FOR REIMBURSEMENT WITHOUT PRIOR AUTHORIZATION. A PHYSICIAN'S SIGNATURE IS REQUIRED. IF THE FORM IS COMPLETED BY A LICENSED PHYSICAL THERAPIST OR OCCUPATIONAL THERAPIST, THE THERAPIST MUST ALSO SIGN THE FORM.

NOTE:This Letter of Medical Necessity should only be completed for manual wheelchairs without custom seating system or adaptive positioning devices. Medical necessity for Power Wheelchairs and Manual or Power Wheelchairs with specialized seating should be documented using JFS 03411.

Consumer Name:		**Birth Date:**	**Medicaid Billing #:**
Residence/Facility:		**Other Insurance:**	
Weight:	**Height:**	**Number of Hours/Day in Wheelchair:**	**Est. Length of Need (# of Months/Yrs.):**
Date of Onset/Injury:		**Diagnosis(es) (include written description and ICD-9 codes):**	
Prognosis:			
Cardio-Respiratory Status:			
Tone/Movement/Strength:			
Orthopedic Considerations:			
Ambulation/Functional Walking Status:			
Bed Confined:		**Chair Confined:**	
Present Equipment **Make:**	**Model:**	**Age of Equipment:**	
Include Beginning and Ending Dates of any Wheelchair Rental Period (to include Short Term-Rental billed to the Department):			
Presenting Problem:	**Equipment Being Requested - New:** ☐ **Used:** ☐ **(Include Make, Model and Serial Number):**		
Equipment Being Requested - Describe Features to Accommodate Growth (for growing children):			
Length of Warranty Period and What is Covered:			
Functional Consideration for Light Weight or Heavy Duty Wheelchairs (other than standard weight):			
Three Most Important Facts Reviewer Should Know: **a.**	**b.**	**c.**	
Therapist's Name			**License #:**
Therapist's Signature			**Date:**
Physician's Name			**License #:**
Physician's Signature:			**Date:**