ONE SOURCE MEDICAL SOLUTIONS, INC.

ONE COMPANY. MULTIPLE SOLUTIONS. ™

LETTER OF MEDICAL NECESSITY FOR A MANUAL WHEELCHAIR

CLIENT NAME: MEDICAID ID:
DATE OF BIRTH: HEIGHT: WEIGHT:
ADDRESS:
TELEPHONE:

DIAGNOSIS CODES (ICD-10): _____, _____ , _____, _____ ,_____

Section A: Basic Qualifying Information for a Wheelchair: *Please answer/circle each question*

YES NO 1. Does the patient have mobility limitation that significantly impairs his/her ability to participate in one or more activities of daily living such as toileting, feeding, grooming, dressing and bathing in their home?

YES NO 2. Does the patient have a mobility limitation that cannot be sufficiently resolved by the use of a cane or walker?

YES NO 3. Does the patient's home provide adequate access between rooms, maneuvering space, and surfaces for use of the manual wheelchair?

YES NO 4. Will the use of a manual wheelchair significantly improve the patient's ability to participate in activities of daily living and will the patient use it on a regular basis in the home?

YES NO 5. Does the patient demonstrate willingness to use the manual wheelchair in their home?

YES NO 6. Does the patient have sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel a manual wheelchair (standard or lightweight) in the home?

YES NO 7. Does the patient have the caregiver who is available, willing, and able to provide assistance w/ the wheelchair?

Section B: Order / Justification of Need

Please Check the type of wheelchair you are ordering.

☐ Standard Manual Wheelchair
- ☐ The patient does not need specialized seating or positioning.
- ☐ The patient is unable to consistently ambulate more than 10 feet.

☐ Lightweight Wheelchair
- ☐ The patient is unable to self-propel a standard manual wheelchair in their home.
- ☐ The patient can and does self-propel in a lightweight manual wheelchair

☐ Heavy Duty Wheelchair (weight requirement >250lbs) Weight:

☐ Extra Heavy-Duty Wheelchair (weight requirement >300lbs) Weight:

☐ Transport Chair ☐ The patient is unable to self-propel and has a caregiver who is available and willing to assist.

Types of Accessories Required: ☐ Oxygen Holder ☐ Elevating Leg Rest Other: _____

Anticipated Length of time patient will Require Wheelchair: Months Needed _____ (99 = Lifetime)

Physician's Name: _____

Physician's Address: _____

Physician / Treating Practitioner Signature: _____

Date Signed: _____ NPI: _____

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