WHEELCHAIR ORDER FORM

Patient Name _____ TEL _____

Address _____ DOB: _____

Diagnosis codes _____Length of Need: _____ HT: _____WT_____

Equipment ordered:

_____ **K0001 Standard Wheelchair**

_____ **K0002 Standard Hemi (low seat) wheelchair** (please answer question below)

Y N The patient requires a lower seat height(17"to18") because of short stature or to enable the patient to place his/her feet on the ground for propulsion.

_____ **K0003 Lightweight Wheelchair** (please answer question below)

Y N The patient cannot self-propel in a standard weight wheelchair in the home and can self-propel in a lightweight wheelchair.

_____ **K0006 Heavy Duty Wheelchair** (over 250lbs)

_____ **K0007 Extra Heavy-Duty Wheelchair** (over 300lbs)

Wheelchair Accessories

_____ **K0195 Elevating Leg Rests**

_____ **E2601 Wheelchair Seat Cushion**

_____ **E1226 Fully Reclining Back**

_____ **E0705 Transfer Board**

_____ **E2611 Wheelchair Back Cushion**

_____ **E0971 Anti-Tipper**

Coverage Questions for Any Wheelchair:

Y N Does the patient have a mobility limitation that significantly impairs his/her ability to participate in one or more mobility related activities of daily living such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home?

Y N Can the patient's mobility limitation be sufficiently resolved by the use of an appropriately fitted cane or walker?

Y N Does the patient's home provide adequate access between rooms, maneuvering space, and surfaces for use of the manual wheelchair that is being provided?

Y N Will the use of the manual wheelchair significantly improves the patient's ability to participate in MRADLs and the patient will use it on a regular basis in the home?

Y N Has the patient expressed an unwillingness to use the manual wheelchair that is provided in the home?

Y N Does the patient have 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 the typical day?

Y N Does the patient have a caregiver who is available, willing, and able to provide assistance with the wheelchair?

Coverage Questions for Elevating Leg Rests:

Y N Does the patient have a musculoskeletal condition or the presence of a cast or brace which prevents 90-degree flexion at the knee?

Y N Does the patient have significant edema of the lower extremities that requires an elevating legrest?

Y N Does the patient meet the criteria for or have a reclining back on the wheelchair?

PLEASE SUPPLY A COPY OF NOTES FROM THE FACE TO THE FACE VISIT
(Please be sure to sign, date, and NPI the end of the patient notes)

Physician Name_____

Address _____

Phone _____ Fax _____NPI _____

Physician Signature Date

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