

# WHEELCHAIR ORDER FORM

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_

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" to 18") 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**

\_\_\_\_\_ **E0705 Transfer Board**

\_\_\_\_\_ **E2601 Wheelchair Seat Cushion**

\_\_\_\_\_ **E2611 Wheelchair Back Cushion**

\_\_\_\_\_ **E1226 Fully Reclining Back**

## 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 improve 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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