Print Form

BlueCross BlueShield of Texas

Wheelchair Medical Necessity and Home Evaluation Verification

Wheelchairs and Accessories
Medical Policy – DME101.010

Please complete all appropriate questions fully.

Suggested medical record documentation:

- Seating Evaluation
- Equipment Recommendation(s) with physician justification(s)
- Physician Prescription

*Failure to include suggested medical record documentation may result in delay or possible denial of request.

Note: For Predetermination, please fully complete and submit the Predetermination Request Form.

PATIENT INFORMATION

Name:	Member ID	Group ID

PROCEDURE INFORMATION

Patient Age _____ Sex: Male Female Height_____ Weight _____

Primary Diagnosis
_____Date_____Duration_____

Secondary Diagnosis _____Date _____Duration_____

Date you examined the patient and attested to the letter of medical necessity _____

What are the change(s) in your patient's medical condition that now impairs his/her mobility?
_____

Until now, what has been your patient's mode of mobility in the home? _____
_____

Is the patient able to safely operate a MWC? _____

If NOT, why? _____
_____
_____
Is the patient able to safely operate and control a POV? _____

Location where MWC or POV will primarily be used? _____

Is the patient's duration of need greater than 6 months? _____

Can the patient safely transfer in and out of a POV? _____

Does the patient have adequate trunk control to safely ride in a POV? _____

List activities for which equipment is primarily to be used: _____
_____
_____

What wheelchair accessories do you anticipate this patient needing, and why? _____

Will the MWC or POV fit through the doorways into and inside of the home? _____

Does the physical layout of the home allow unhindered use of the MWC or POV? _____

Are there any surfaces or obstacles inside the home that may render the MWC or POV unusable in the home? _____

The patient's home should provide adequate access, maneuvering space, and surfaces, as well as prevailing temperature and physical layout, for the safe operation of the MWC or POV. Overall, is the home environment conducive both to getting the MWC or POV into the home and to safe operation within the home? _____

Are the patient's physical and mental capabilities adequate and appropriate for the device requested? _____

Is the patient motivated and willing to use the device routinely? _____

The provider attests that the patient and the home have been evaluated, that the equipment requested is medically necessary and appropriate for the patient, that the home environment is conductive to the safe and successful operation of the device, and that this questionnaire has been answered honestly and accurately.

Signature: _____Date: _____

Physician Signature: _____Date: _____

Revised 07/2009