Medicaid

Montana Medicaid Certificate of Medical Necessity

Durable Medical Equipment (DME) and Supplies (Rev. October 2014)

Manual Wheelchair

Patient Name, Address, Telephone Number, and Date of Birth **Medicaid ID Number**_____	**Physician Name, Address, and Telephone Number** **NPI Number** _____

Diagnosis	**Height**	**Weight**

Prognosis	**Estimated Length of Need (Months) 1–99 (99=Lifetime)**

1. Does the patient currently own a wheelchair? ☐ Yes **If yes**, provide information below. ☐ No **If no**, go to # 2.
   - 1a. Date of purchase. 1a. _____
   - 1b. Type of wheelchair. 1b. _____
   - 1c. Condition. 1c. _____
   - 1d. Original supplier of current wheelchair. 1d. _____
   - 1e. Repairs/modifications within last six months. 1e. _____
2. Residence ☐ Home ☐ Nursing Home ☐ Hospital Rehab Unit ☐ Institution ☐ Group Home ☐ Other_____
3. Does the patient require and use a wheelchair to move around in their residence? ☐ Yes ☐ No
4. How many hours per day does the patient usually spend in the wheelchair? (1–24 hours; round up to the next hour.) _____
5. Is the patient able to operate any type of manual wheelchair? ☐ Yes ☐ No
6. Does the patient have the **physical** and **mental** ability to operate the requested wheelchair in a safe, controlled manner? ☐ Yes ☐ No
7. Can the patient ambulate? ☐ Yes ☐ No **If yes**, how and how far? _____
8. Will the patient's home and transportation accommodate the requested wheelchair? ☐ Yes ☐ No
9. Narrative description of **all** items, accessories, sizes and options to be included regarding this wheelchair. If additional space is needed, a continued narrative can be attached to this document as long as the pertinent patient and physician information is included at the top of the attachment. Physician's signature must also be included on the attached document).
   ☐ **Yes**, additional attachments **are** included. ☐ **No**, additional attachments **are not** included.

I certify that I am the treating physician identified in this form. I certify that the medical necessity information contained in this document and its attachments are true, accurate, and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in this document may subject me to civil or criminal liability.

Signature and date stamps are not acceptable.

_____ _____

Physician's Signature **Date (mm/dd/yyyy)**