BlueCross BlueShield of Oklahoma

Wheelchair Medical Necessity and Home Evaluation Verification

Wheelchairs and Accessories Medical Policy – DME101.010 for Manual Wheelchair (MWC) and POVs (i.e., Power Wheelchair, Scooter, Other Power-operated Vehicle)

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 Predeterminations, please fully complete and submit the Predetermination Request form (www.bcbsok.com/pdf/predetermination_request_form.pdf) with this 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?

PROCEDURE INFORMATION (CONT'D)

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