FastServ Mobility, Inc.
Ph: 510.685.4397 Fax: 510.787.2762

State of California - Health and Human Services Agency — California Department of Health Services

CERTIFICATE OF MEDICAL NECESSITY FOR A MOTORIZED WHEELCHAIR, CUSTOM OR STANDARD

The DME provider must complete all applicable areas not completed by the clinician or therapist.

Dear Clinician/DME Provider: Cooperation in completing this form will ensure that the beneficiary receives full Medi-Cal consideration regarding the request for a motorized wheelchair. Medi-Cal reimbursement is based on the least expensive medically appropriate equipment that meets the patient's medical need.

Incomplete information will result in a deferral, denial or delay in payment of the claim.

REQUIRES THE ATTENDING CLINICIAN TO COMPLETE AND SIGN

SECTION 1—Clinician's Information:

Clinician Name *(Print)* Last	First	Phone Number ( )	License Number

Address Street	City	State	ZIP

① Clinician's description of the patient's current functional status and need for the requested equipment:

SECTION 2—Patient's Information: New Rx ***(For Rx Renewal, please also complete 2A below)***

Patient Name *(Print)* Last	First	Phone Number ( )	Date of Birth mm / dd / yy	Medi-Cal Number

Address Street	City	State	ZIP

② Date of last face-to-face visit with the beneficiary: _____

Is this beneficiary expected to be institutionalized within the next 10 months? Yes ❒ No ❒ Explain "Yes" answer: _____

Equipment required for:

❒ Less than 10 months *(code the TAR for a rental)*

❒ More than 10 months *(code the TAR for a purchase)*

SECTION 2A—For Renewal

Verification of continued medical necessity and continued usage by the beneficiary must be done at each TAR renewal.

SECTION 3—Motorized Wheelchair Requested:

a) Standard HCPCS Code(s):	b) Custom HCPCS Code(s):
c) Replacing existing equipment? ❒ Yes ❒ No Model/Serial #	If yes, explain why:
d) Attach repair estimate if replacement with similar equipment is requested.	
e) Other DME the beneficiary has:	f) Current wheelchair:
g) How many hours per day of usage:	h) Accessories requested and why (use attachments):
i) Custom features requested and why:	j) Have they tried the chair? ❒ Yes ❒ No

SECTION 4—Diagnoses Information:

④ Diagnoses: _____

Date of onset: _____

SECTION 5—Pertinent History:

⑤ Pressure Sores Present: ❒ Yes ❒ No

Beneficiary has a history of pressure sores: ❒ Yes ❒ No

Beneficiary lacks protective sensation and is at risk for developing sores: ❒ Yes ❒ No

Beneficiary's protective sensation is intact: ❒ Yes ❒ No

If sores are present, location and stage: _____

SECTION 6—Pertinent Exam Findings:

⑥ Upper Extremity: Weakness ❒ Paralysis ❒ Contractures ❒

Comments: _____

Lower Extremity: Weakness ❒ Paralysis ❒ Contractures ❒ Edema ❒

Amputee ❒ Level: Left ❒ Right ❒ Cast ❒ Ataxia ❒

Comments: _____ HT: _____ WT: _____

Sitting posture/Deformity: _____ Cognitive status: _____

Requires wheelchair supervision: ❒ Yes ❒ No Vision: Impaired ❒ Normal ❒

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SECTION 7—Living Environment:

House/condominium ☐ Apartment ☐ Stairs ☐ Elevator ☐ Ramp ☐ Hills ☐ SNF ☐ ICF/DD ☐ B&C ☐
Doorway widths and home layout for adequate wheelchair use indoors verified except: Bathroom ☐ Bedroom ☐ Kitchen ☐ Other: ☐
Living Assistance: Lives Alone ☐ With Other Person(s) ☐ Alone Most of the Day ☐ Alone at Night ☐
Attendant Care: ☐ Live in attendant or _____ Hours/day ☐ Homemaker Hours _____
Transportation:
To/from medical appointments? ☐ Yes Local Community? ☐ Yes ☐ No Beneficiary drives from the wheelchair? ☐ Yes ☐ No
Tie-down system: _____
Public Transportation: _____

SECTION 8—Activity Level:

Number of hours per day in the wheelchair: _____ Distances the beneficiary pushes/drives daily: _____
Beneficiary will use the wheelchair: At home ☐ Outside ☐ For physician visits ☐ Job related activities ☐ School ☐
Social Activities ☐ SNF ☐ ICD/DD ☐
Who will propel this chair? ☐ Beneficiary Other: _____
Beneficiary can independently propel a manual wheelchair: ☐ Yes ☑ No At Home ☐ In the community ☐
Beneficiary can disassemble this type of manual wheelchair and independently transfer self and chair to a motor vehicle: ☐ Yes ☑ No
Beneficiary is unable to effectively propel any manual wheelchair: ☑ Yes ☐ No

SECTION 9—Ambulation:

Beneficiary is independently ambulatory: ☐ Yes ☑ No Beneficiary is unable to walk: ☑ Yes ☐ No
Beneficiary ambulation is non-functional and limited by: _____
Beneficiary's ambulation ability is expected to change: ☐ Yes ☐ No Explain "Yes" Answer: _____

Beneficiary is scheduled for additional lower extremity medical/surgical intervention(s). ☐ Yes ☐ No Explain "Yes" Answer:

SECTION 10—Motorized Wheelchair Base and Accessories:

1. Does the beneficiary require and use the wheelchair to move around in their place of residence? ☑ Yes ☐ No
2. Does the beneficiary have quadriplegia, a fixed hip angle, a trunk cast or brace, excessive extensor tone of the trunk muscles or need to rest in a recumbent position two or more times during the day? ☐ Yes ☐ No
3. The beneficiary has a cast, brace or musculoskeletal condition, which prevents 90 degrees of flexion of the knee, or does the beneficiary have significant edema of the lower extremities? ☐ Yes ☐ No
4. How many hours a day is this beneficiary expected to spend in this wheelchair? _____ (Round to nearest hour)
5. Does the beneficiary have a need for arm height different than those available using non-adjustable arms? ☐ Yes ☐ No
6. Does the beneficiary have severe weakness of the upper extremities due to a neurological, muscular, or cardiopulmonary disease/condition that precludes the use of a manual wheelchair? ☑ Yes ☐ No
7. Is this beneficiary able to safely operate the requested equipment? ☑ Yes ☐ No

SECTION 11—Narrative description of the wheelchair and cost and justification for higher cost frames, second wheelchair, tilt recline

Manufacturer: Model: Provider Name:
Provider Location:

SECTION 12—DME provider/Therapist attestation and signature/date:

By my signature below, I certify to the best of my knowledge that the information contained in this Certificate of Medical Necessity is true, accurate and complete and I understand that any falsification, omission or concealment may subject me to criminal liability under the laws of the State of California.

Name of therapist answering these sections, if other than prescribing clinician or DME provider (please print):

Name: _____ *(Please print)* Title: _____ *(OT, PT, RESNA, etc.)* DME Provider Name: _____ *(Please print)*

✍ _____ *(Use Ink - A signature stamp is not acceptable)* Date: _____ ✍ _____ *(Use Ink - A signature stamp is not acceptable)* Date: _____

SECTION 13—Clinician attestation and signature/date:

I certify that I am the clinician identified in this document. I have reviewed this Certificate of Medical Necessity and I certify to the best of my knowledge that the medical information is true, accurate, current and complete, and I understand that any falsification, omission, or concealment may subject me to criminal liability under the laws of the State of California.

Clinician's Signature: ✍ _____ *(Use Ink - A signature stamp is not acceptable)* Date: _____