# Manual Wheelchair Evaluation / Certificate of Medical Necessity

Initial Date ___/___/___ Revised Date ___/___/___ HCPC: _____ _____ Place of Service: 12

Length of Need (# of months): _____ 1-99 (99=lifetime) Diagnosis Codes (ICD 10): _____ _____ _____ _____

**Patient Name, Address, Telephone**

PT DOB: ___/___/___ Sex: ____ (M/F) HT: ____ (in) WT: ____ (lbs)

**Supplier Name, Address, Telephone / Fax** NPI: 1568642056 TAX ID: 351994022
Kesling Home Health Care
1115 W Market St
Logansport, IN 46947
Phone: (574) 735-0082 **FAX:** (574) 753-3910

**Physician Name, Address, Telephone / Fax** NPI: _____

Phone: ( ) FAX: ( )

| | | |
|---|---|---|
| ☐ YES ☐ NO | Does the patient require a Manual Wheelchair to move around in their residence? |
| ☐ YES ☐ NO | Is there a mobility limitation causing an inability to safely participate in one or more Mobility Related Activities of Daily Living in a reasonable time frame? **Explain:** |
| ☐ YES ☐ NO | Are there cognitive or sensory deficits (awareness / judgment / vision / etc) that limit the user's ability to safely participate in one or more MRADL's or ADL's? **Explain:** |
| ☐ YES ☐ NO | If yes, can they be accommodated / compensated for to allow use of a manual wheelchair to participate in MRADL's? |
| ☐ YES ☐ NO | Does the user demonstrate the ability or potential ability and willingness to safely use the Manual Wheelchair? |
| ☐ YES ☐ NO | Can the mobility deficit be sufficiently resolved with only the use of a cane or a walker? |
| ☐ YES ☐ NO | Does the user's environment support the use of a Manual Wheelchair? (adequate access between rooms, maneuvering space, surface) |
| ☐ YES ☐ NO | Will the use of the Manual Wheelchair significantly improve the patients ability to participate in MRADL's? |
| ☐ YES ☐ NO | Does the patient has sufficient upper extremity function and other physical and mental capabilities needed to safely propel the Manual Wheelchair and/or the patient have a caregiver who is available, willing, and able to provide assistance with the Manual Wheelchair? |
| ☐ YES ☐ NO | Does the patient have a cast, brace, or musculoskeletal condition, which prevents 90 degree flexion of the knee, or does the patient have significant edema of the lower extremities that requires an elevating leg rest? |

Physician Signature: _____ Date:_____