U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0679

CERTIFICATE OF MEDICAL NECESSITY

DMERC 02.03A

MOTORIZED WHEELCHAIRS

SECTION A **Certification Type/Date:** **INITIAL** ___/___/___ **REVISED** ___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER
(___)___-____ HICN _____	(___)___-____ NSC # _____
PLACE OF SERVICE _____ NAME and ADDRESS of FACILITY if applicable (See Reverse)	HCPCS CODE _____ _____ _____ _____
	PT DOB ___/___/___; **Sex** ___ **(M/F)** ; **HT.**_____**(in.)** ; **WT.**_____**(lbs.)**
	PHYSICIAN NAME, ADDRESS, TELEPHONE and UPIN NUMBER (___)___-____ UPIN # _____

SECTION B **Information in This Section May Not Be Completed by the Supplier of the Items/Supplies.**

EST. LENGTH OF NEED (# OF MONTHS): _____ **1-99 (99=LIFETIME)** **DIAGNOSIS CODES (ICD-9):** _____ _____ _____ _____

ITEM ADDRESSED	ANSWERS	ANSWER QUESTIONS 1, 6 AND 7 FOR MOTORIZED WHEELCHAIR BASE, 1-5 FOR WHEELCHAIR OPTIONS/ACCESSORIES. (Circle **Y** for Yes, **N** for No, or **D** for Does Not Apply, unless otherwise noted.)
Motorized Whlchr Base and All Accessories	Y N D	1. Does the patient require and use a wheelchair to move around in their residence?
Reclining Back	Y N D	2. Does the patient have quadriplegia, a fixed hip angle, a trunk cast or brace, excessive extensor tone of the trunk muscles or a need to rest in a recumbent position two or more times during the day?
Elevating Legrest	Y N D	3. 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 legrest, or is a reclining back ordered?
Adjustable Height Armrest	Y N D	4. Does the patient have a need for arm height different than that available using non-adjustable arms?
Reclining Back; Adjustable Height Armrest	_____	5. How many hours per day does the patient usually spend in the wheelchair? (1–24) (Round up to the next hour)
Motorized Whlchr Base	Y N D	6. Does the patient have severe weakness of the upper extremities due to a neurologic, muscular, or cardiopulmonary disease/condition?
Motorized Whlchr Base	Y N D	7. Is the patient unable to operate any type of manual wheelchair?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):
NAME: _____ TITLE: _____ EMPLOYER: _____

SECTION C **Narrative Description of Equipment and Cost**

(1) Narrative description of all items, accessories and options ordered; **(2)** Supplier's charge; and **(3)** Medicare Fee Schedule Allowance for each item, accessory, and option. *(See instructions on back.)* If additional space is needed, list wheelchair base and most costly options/accessories on this page and continue on HCFA Form 854.

❒ **CHECK HERE IF ADDITIONAL OPTIONS/ACCESSORIES ARE LISTED ON ATTACHED HCFA FORM 854**

SECTION D **Physician Attestation and Signature/Date**

I certify that I am the treating physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE _____ DATE ____/____/____ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

Mobility Assistive Equipment – Face to Face Examination Report

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Sex: ____

Address: _____ City: _____ State: ____ Zip: _____

Primary Insurance: Secondary Insurance: SSN: Tel:

PHYSICIAN INFORMATION OR TREATING PRACTITION INFORMATION

Doctors Name: _____ Date of Last Visit: _____

Address: _____ City: _____ State: ____ Zip: _____

UPIN #: NPI #: Medicaid #: Tel:

CURRENT SYMPTOMS, RELATED DIAGNOSES, AND HISTORY

Please describe the reason for this mobility evaluation

_____

_____

_____

Please list previously diagnosed conditions that relate to the current office visit

_____

_____

_____

PHYSICAL EXAM

Ht:	Wt:	B/P:	Pulse (resting):	Respiratory: Normal Labored at times Is O2 required Y ☐ N ☐
Any Current pressure sores? Y ☐ N ☐ Location:				
Poor Balance: Y ☐ N ☐	History or Risk of Falls: Y ☐ N ☐	Poor Endurance: Y ☐ N ☐		
Cachexia (severe weakness): Y ☐ N ☐	Obesity: Y ☐ N ☐	Significant Edema: Y ☐ N ☐		
Holds to furniture/walls for mobility: Y ☐ N ☐				
Neck, Trunk and Pelvis Posture and Flexibility: Good ☐	Limited ☐	Severely Limited ☐		

Mobility Assistive Equipment – Face to Face Examination Report

FUNCTIONAL ASSESMENT

Question	You Answers below must be justified by your narrative responses	
1. Does your patient have a mobility limitation that impairs participation in Mobility required Activities of Dally Living (MRADLs) in the home? If YES, why:_____	☐ YES ☐ NO	GO TO QUESTION **2** STOP – NO MAE
2. Can their limitations be compensated by the addition of MAE to improve the ability to participate in MRADLs in the home? If YES, why:_____	☐ YES ☐ NO	GO TO QUESTION **3** STOP – NO MAE
3. Is your patient or their caregiver capable and willing to operate the MAE safety in the home?	☐ YES ☐ NO	GO TO QUESTION **4** STOP – NO MAE
4. Can their mobility deficit be safety resolved by a cane or walker? If NO, why:_____	☐ YES ☐ NO	STOP – ORDER CANE OR WALKER GO TO QUESTION **5**
5. Dos your patient's home environment support use of a wheelchair or POV? (Home assessment to be completed by Medical Equipment Supplier)	☐ YES ☐ NO	GO TO QUESTION **6** STOP – NO MAE
6. Does your patient have the upper extremity function to safely propel a manual wheelchair to participate in MRADLs in the home? If NO, why:_____	☐ YES ☐ NO	STOP – ORDER MANUAL WHEELCHAIR GO TO QUESTION **7**
7. Does your patient have sufficient strengths and trunk stability to operate a POV in the home? Please Explain:_____	☐ YES ☐ NO	GO TO QUESTION **8** GO TO QUESTION **9**
8. Is your patient able to safely maneuver a POV in the Home?	☐ YES ☐ NO	STOP – ORDER POV GO TO QUESTION **9**
9. Does your patient need the additional features (i.e. optimal maneuverability of use, upgradeable/adaptable seating, etc.) Of power wheelchair to participate in MRADLs in the home? If Yes, why: _____	☐ YES ☐ NO	GO TO QUESTION **10** STOP – NO MAE
10. Is your patient safe and able to maneuver wheelchair in the home?	☐ YES ☐ NO	STOP – ORDER PWC STOP

The Information provided is a true and accurate representation of my patient's current condition. I hereby incorporate this document into my patient's medical record. This document is supported by additional medical records in my patient's file.

Physician or Treating Practitioner Signature: **Date:**