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

FORM APPROVED
OMB NO. 0938-0679

CERTIFICATE OF MEDICAL NECESSITY

DMERC 02.03B

MANUAL WHEELCHAIRS

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

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER
Francisco Delapava
42-10 82nd Street Apt. 5E
Elmhurst, NY 11373
(_ _ _) _ _ _ - _ _ _ _ HICN 4231359F

SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER
JAG Orthotics & Prosthetics, Inc.
84-08 37th Avenue
Jackson Heights, NY 11372
(_ _ _) _ _ _ - _ _ _ _ NSC # 1811238611

PLACE OF SERVICE 12
NAME and ADDRESS of FACILITY if applicable (See Reverse)
Integra Partners
100 Wall Street Suite 2502
New York, NY 10005

HCPCS CODE
K0006
E1226
E2601
E2611

PT DOB ___/___/___; Sex M (M/F); HT. 71 (in.); WT. 375 (lbs.)

PHYSICIAN NAME, ADDRESS, TELEPHONE and UPIN NUMBER
Dr. Yanguan Wu
7901 Broadway
Elmhurst, NY 11373
(_ _ _) _ _ _ - _ _ _ _ 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, 5, 8 AND 9 FOR MANUAL WHEELCHAIR BASE, 1-5 FOR WHEELCHAIR OPTIONS/ACCESSORIES. (Circle **Y** for Yes, **N** for No, or **D** for Does Not Apply, unless otherwise noted.)
Manual 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 Ht. Armrest; Any Type Ltwt. Whlchr	_____	5. How many hours per day does the patient usually spend in the wheelchair? (1–24) (Round up to the next hour)
Any Type Ltwt. Whlchr	Y N D	8. Is the patient able to adequately self-propel (without being pushed) in a standard weight manual wheelchair?
Any Type Ltwt. Whlchr	Y N D	9. If the answer to question #8 is "No," would the patient be able to adequately self-propel (without being pushed) in the wheelchair which has been ordered?

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.

K0006 - Heavy Duty Manual Wheelchair (Rental) $759.48

E1226 - Manual Fully Reclining Back (Purchase) $478.08 Each

E2602 - Seat Cushion >22 inches(Purchase) $113.76 Each

E2612 - Back Cushion Width >22 inches $251.19 Each

E0973 - Adjustable Height Arm Rest (Purchase) $82.34 Each

E0978 - Seat Belt (Purchase) $35.59 Each

E0990 - Elevating Leg Rest (Purchase) $98.00 Each

E0951 - Heel Loop Holder (Purchase) $16.40 Each

E0971 - Anti-Tipping Device (Purchase) $38.22 Each

❒ 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)