## **CERTIFICATE OF MEDICAL NECESSITY**

MANUAL WHEELCHAIRS				
SECTION A	Certification Type/Date:		INITIAL//	
PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER			SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER	
( )	HICN		() NSC #	
() HICN			PT DOB/; Sex(M/F); HT(in.); WT(lbs.)	
PLACE OF SERVICE HCPCS CODE  NAME and ADDRESS of FACILITY if applicable (See Reverse)		HCPCS CODE	PHYSICIAN NAME, ADDRESS, TELEPHONE and UPIN NUMBER  () UPIN #	
SECTION B In	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	OPTIONS/ACCESSO	DNS 1, 5, 8 AND 9 FOR MANUAL WHEELCHAIR BASE, 1-5 FOR WHEELCHAIR ORIES.  for No, or <b>D</b> for Does Not Apply, unless otherwise noted.)	
Manual Whichr Base And All Accessories	Y N D	Does the patient require and use a wheelchair to move around in their residence?		
Reclining Back	YND	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	YND	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	YND	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	Is the patient able to wheelchair?	to adequately <u>self-propel</u> (without being pushed) in a standard weight manual	
Any Type Ltwt. Whlchr	Y N D	· ,	uestion #8 is "No," would the patient be able to adequately self-propel (without the wheelchair which has been ordered?	
			ER THAN PHYSICIAN (Please Print): E: EMPLOYER:	
SECTION C Narrative Description of Equipment and Cost				
Allowance for each	n item, accessory, a	and option. (See inst on this page and cor	as ordered; (2) Supplier's charge; and (3) Medicare Fee Schedule structions on back.) If additional space is needed, list wheelchair base ontinue on HCFA Form 854.	
SECTION D				
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				
EST. LENGTH OF NEED (# CO ITEM ADDRESSED  Manual Whichr Base And All Accessories  Reclining Back  Elevating Legrest  Adjustable Height Armrest  Reclining Back; Adjustable Ht. Armrest; Any Type Ltwt. Whichr  Any Type Ltwt. Whichr  NAME OF PERSON ANSW NAME:  SECTION C  (1) Narrative description Allowance for each and most costly opton and most costly opton and most costly opton Section B is true, accurate section may subject me to civ	ANSWERS  Y N D  Y N D  Y N D  Y N D  Y N D  Y N D  Y N D  Y N D  ZERING SECTION B of the land complete, to the land complete, to the land complete, to the land complete of the l	ANSWER QUESTION OPTIONS/ACCESSO (Circle Y for Yes, N for 1. Does the patient reduced of the trunk middle of the knee, or does elevating legrest, of 4. Does the patient has arms?  5. How many hours per next hour)  8. Is the patient able to wheelchair?  9. If the answer to quebeing pushed) in the QUESTIONS, IF OTHE TITLE  Narrative Deessories and options and option. (See instead options on this page and corrected of the patient and corrected of the patient and options and option. (See instead options on this page and corrected options and option of the page and corrected options on the page and corrected options and option of the page and corrected options on the page and corrected options on the page and corrected options of the page and corrected options options of the page and corrected options of the page and corrected options options options of the page and corrected options options options options options options options options options opt	Not Be Completed by the Supplier of the Items/Supplies.  DIAGNOSIS CODES (ICD-9):  DIAGNOSIS CODES (ICD-9):  DINS 1, 5, 8 AND 9 FOR MANUAL WHEELCHAIR BASE, 1-5 FOR WHEELC ORIES. for No, or <b>D</b> for Does Not Apply, unless otherwise noted.) equire and use a wheelchair to move around in their residence?  nave quadriplegia, a fixed hip angle, a trunk cast or brace, excessive extenson uscles or a need to rest in a recumbent position two or more times during the state of the patient have significant edema of the lower extremities that requires a or is a reclining back ordered?  have a need for arm height different than that available using non-adjustable per day does the patient usually spend in the wheelchair? (1–24) (Round up to adequately self-propel (without being pushed) in a standard weight manual estion #8 is "No," would the patient be able to adequately self-propel (without he wheelchair which has been ordered?  ER THAN PHYSICIAN (Please Print):  E: EMPLOYER:  Eescription of Equipment and Cost  as ordered; (2) Supplier's charge; and (3) Medicare Fee Schedule structions on back.) If additional space is needed, list wheelchair back on the continue on HCFA Form 854.  FADDITIONAL OPTIONS/ACCESSORIES ARE LISTED ON ATTACHED HCFA Form  Attestation and Signature/Date  I have received Sections A, B and C of the Certificate of Medical Necessity (income and I understand that any falsification, omission, or concealment of material fact in and I understand that any falsification, omission, or concealment of material fact in the continual contribution of the medical necessity informs and I understand that any falsification, omission, or concealment of material fact in the contribution of the certificate of Medical necessity informs and I understand that any falsification, omission, or concealment of material fact in the contribution of the certificate of t	