Certification of Medicare Requirements for MANUAL WHEELCHAIRS

Patient Name:	
Patient Date of Birth:	
Address:	
Phone #:	
Requested DME:	
Patient Diagnosis (ICD-10):	
Prescribing Physician's Name:	
NPI / Licence number:	
Address:	

I have reviewed Medicare coverage criteria below and checked off the necessary criteria that would qualify the Patient for the requested DME Equipment:

General Coverage Criteria for Manual Standard Wheelchair:

☐Criterion A, B, C, D, and E are met; and

☐A. The beneficiary has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADLs) such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home. A mobility limitation is one that:

☐1. Prevents the beneficiary from accomplishing an MRADL entirely, or

☐2. Places the beneficiary at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL; or

☐3. Prevents the beneficiary from completing an MRADL within a reasonable time frame.

☐B. The beneficiary's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker.

☐C. The beneficiary's home provides adequate access between rooms, maneuvering space, and surfaces for use of the manual wheelchair that is provided.

☐D. Use of a manual wheelchair will significantly improve the beneficiary's ability to

participate in MRADLs and the beneficiary will use it on a regular basis in the home.

☐E. The beneficiary has not expressed an unwillingness to use the manual wheelchair that is provided in the home.

☐Criterion F or G is met:

☐F. The beneficiary has sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the manual wheelchair that is provided in the home during a typical day. Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function; or

☐G. The beneficiary has a caregiver who is available, willing, and able to provide assistance with the wheelchair.

Transport Chairs

☐General criteria A-E and G above are met; and

☐Transport chair is being used as an alternative to a standard MWC (K0001).

☐Description of why the beneficiary is unable to make use of a standard MWC (K0001-K0005) on their own; and

☐Provide specific information that the beneficiary has a caregiver who is available, willing, and able to provide assistance with the wheelchair.

Lightweight Wheelchair (K0003)

☐General criteria noted above are met; and

☐Medical records support the beneficiary:

☐Cannot self-propel in a standard wheelchair; and

☐Can and does self-propel in a lightweight wheelchair.

High Strength Lightweight Wheelchair (K0004)

☐General criteria noted above are met; and

☐Medical records support the beneficiary:

☐Self-propels the wheelchair while engaging in frequent activities that cannot be performed in a standard or lightweight wheelchair; and/or

☐Requires seat width, depth, or height that cannot be accommodated in a standard, lightweight, or hemi-wheelchair and spends at least two hours per day in the wheelchair.

Heavy-Duty Wheelchair (K0006)

☐General criteria noted above are met; and

☐Medical records support the beneficiary:

☐Weighs more than 250 pounds; or

☐Has severe spasticity.

_____	_____	_____
(Physician's Name and NPI/License Number)	(Physician's Signature)	(Date)