

**Review Request  
for Manual Wheeled Mobility Assist Device**

Please fax the completed form to **1-800-823-5520**.  
If you have questions, call **1-866-902-1689** during regular business hours.

Policy Last Review Date: 05/21/09	Policy Effective Date: 07/15/09	Provider Tool Effective Date: 8/10/09
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Member Name:	Date of Birth:
Insurance Identification Number:	Member Phone Number:

Ordering Provider Name and Specialty:	Provider ID Number:
Office Address:	
Office Phone Number:	Office Fax Number:

Rendering Provider Name and Specialty:	Provider ID Number:
Office Address:	
Office Phone Number:	Office Fax Number:

Facility Name:	Facility ID Number:
Facility Address:	

Date/Date Range of Service:	Place of Service: <input type="checkbox"/> Home <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Other: _____
Service Requested (CPT if known):	
Diagnosis (ICD-9) if known:	

**Please check all that apply to the member:**

**DEVICES:**

- Request is for a manual wheeled mobility device (Please complete below)
  - Standard manual wheelchair
  - Hemi-height wheelchair
  - Lightweight wheelchair
  - High-strength, lightweight wheelchair
  - Heavy duty, bariatric wheelchair
  - Ultra lightweight wheelchair
  - Super ultra lightweight wheelchair
  - Other: \_\_\_\_\_

- An assessment (e.g., physical therapy, occupational therapy) shows that the member lacks the functional mobility to safely and efficiently move about to complete activities of daily living (ADLs) in the home setting
- Without the use of a wheelchair, the member would otherwise be bed/chair confined
- Other assistive devices (e.g., canes, walkers) are insufficient or unsafe to completely meet functional mobility needs
- The member's living environment supports the use of a wheeled mobility device
- The member is willing and able to consistently operate the manual mobility device safely
- A caretaker must be trained and be willing and able to assist with or operate the manual wheeled mobility device when the member's condition precludes self operation of the manual wheeled mobility device
- A backup manual wheeled mobility device in case the primary device requires repair
- A device which exceeds that which is medically necessary to treat the member's condition
- Other: \_\_\_\_\_

**OPTIONS/ACCESSORIES:**

- Request is for an option or accessory on a manual wheeled mobility device (Please complete below)
 

<input type="checkbox"/> Adjustable arm rest option	<input type="checkbox"/> Mobility assistive device rack for automobiles	<input type="checkbox"/> Snow tires for the device
<input type="checkbox"/> Adjustable combination skin protection and positioning seat cushion	<input type="checkbox"/> One-arm drive	<input type="checkbox"/> Support frames for cellular phone/CDs/etc.
<input type="checkbox"/> Arm trough	<input type="checkbox"/> Pelvic strap	<input type="checkbox"/> Swing away hardware
<input type="checkbox"/> Auto carrier	<input type="checkbox"/> Positioning accessory	<input type="checkbox"/> Tilt-in spacing
<input type="checkbox"/> Baskets/bags/backpacks/pouch used to transport personal belongings	<input type="checkbox"/> Positioning back cushion	<input type="checkbox"/> Towing package
<input type="checkbox"/> Chest strap	<input type="checkbox"/> Positioning seat cushion	<input type="checkbox"/> Transit options, tie downs
<input type="checkbox"/> Crutch and cane holder	<input type="checkbox"/> Prefabricated plastic or foam vest type trunk support designed to be worn over clothing and not attached to device	<input type="checkbox"/> Nonadjustable combination skin protection and positioning seat cushion
<input type="checkbox"/> Cup holders	<input type="checkbox"/> Prefabricated plastic-frame back support that can be attached to the device that doesn't replace the back	<input type="checkbox"/> Trunk loader, assists in lifting the assistive device into a van
<input type="checkbox"/> Elevating leg rests	<input type="checkbox"/> Ramps used to allow entrance or exit from home	<input type="checkbox"/> Upgrading for racing or sports
<input type="checkbox"/> Firearm/weapon holder/support	<input type="checkbox"/> Safety belt	<input type="checkbox"/> Van modifications, van lifts, hand controls, etc. that allow transportation or driving while seated in the manual wheeled mobility device
<input type="checkbox"/> Frame/holder for ice chest	<input type="checkbox"/> Seat lift mechanisms	
<input type="checkbox"/> Gloves	<input type="checkbox"/> Semi or fully reclining back option	
<input type="checkbox"/> Hemi-height		
<input type="checkbox"/> Lifts providing access to stairways or car trunks		
<input type="checkbox"/> Other: _____		

- The options or accessories are necessary for the member to function in the home and perform the activities of daily living
- Manual wheeled mobility device and/or related options that are generally intended for outdoor use
- An option which exceeds that which is medically necessary to treat the member's condition
- Device options or upgrades that allow the member to perform leisure or recreational activities
- Individual requires arm rest that is different than that available using nonadjustable armrests
- Member spends at least 2 hours a day in the wheelchair
- The member has quadriplegia, hemiplegia, or uncontrolled arm movements
- The member is wheelchair confined and can not reposition self, operates a manual tilt and requires tilt in space feature to medically manage pressure relief and/or spasticity/tone .
- The member requires a different height to be able to use one or both feet to self propel the manual wheelchair
- Member needs to self propel in a forward motion with only one upper extremity.
- Swing away, retractable, or removable hardware is used to move the component out of the way to enable the member to transfer to a chair or bed.
- The member has a musculoskeletal condition or the presence of a cast or brace which prevents 90 degree flexion at the knee.
- There is significant edema of the lower extremities that requires elevation of the legs.
- The member has weak upper body muscles, upper body instability or muscle spasticity

- The member cannot reposition self and has a medical need to rest in a recumbent position two or more times during the day
- Transfer between wheelchair and bed is very difficult because of quadriplegia, fixed hip angle, trunk or lower extremity casts/braces or excess extensor tone of the trunk muscles
- The member has significant postural asymmetries due to any of the following: (please check all that apply)
  - anterior horn cell diseases, including amyotrophic lateral sclerosis
  - cerebral palsy
  - childhood cerebral degeneration
  - hemiplegia due to stroke
  - monoplegia of the lower limb
  - Other: \_\_\_\_\_
  - multiple sclerosis
  - muscular dystrophy
  - other demyelinating disease
  - paraplegia
  - Parkinson's disease
  - post polio paralysis
  - quadriplegia
  - spina bifida
  - spinocerebellar disease
  - torsion dystonias
  - traumatic brain injury
  - traumatic brain injury resulting in quadriplegia
- The member has current or past history of a pressure ulcer on the area of contact with the seating surface
- The member has absent or impaired sensation in the area of contact with the seating surface
- The member is unable to carry out a functional weight shift

**REPAIRS/REPLACEMENT:**

- The repair is needed for normal wear
- The repair is needed for accidental damage
- The member's condition has changed warranting additional or different equipment and/or options. Please provide documentation.

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This request is being submitted:

- Pre-Claim
- Post-Claim. If checked, please attach the claim or indicate the claim number: \_\_\_\_\_
- By checking this box, I attest the information provided is true and accurate to the best of my knowledge. I understand that BlueChoice HealthPlan Medicaid may perform a routine audit and request the medical documentation to verify the accuracy of the information reported on this form.

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Name and Title of Provider or Provider Representative  
Completing Form (Please Print)\*

Date

**\*The attestation fields must be completed by a provider or provider representative in order for the tool to be accepted.**