

**Review Request  
for Power 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.

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 powered wheeled mobility device (Please complete below)
  - Powered wheelchair
  - Scooter or power-operated vehicle
  - Custom-powered wheelchair
  - Motorized wheelchair for a child two years of age or older with severe motor disability
  - Backup powered wheeled mobility device
  - Other: \_\_\_\_\_

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- 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)
- Without the use of a powered mobility device, 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 power wheeled mobility device
- The member is willing and able to consistently operate the power wheeled mobility device safely and effectively
- The member is unable to operate a *manual* wheeled mobility device
- The member's medical condition requires a power wheeled mobility device for long-term use of at least 6 months to one year
- The power wheeled mobility device is ordered by the physician responsible for the individual's care
- A backup power wheeled mobility device is being requested in case the primary device requires repair
- The member is capable of ambulation within the home but requires a power vehicle for movement outside the home
- The vehicle is generally intended for outdoor use due to the size or other features
- A device which exceeds the basic device requirements for the member's condition or needs
- The member has unique needs that require a substantially modified custom powered wheelchair because the features needed are not available on an already manufactured device.

Please list unique needs/features: \_\_\_\_\_

- The child's condition requires a wheelchair and the child is unable to operate the wheel chair manually
- The child has demonstrated the ability to safely and effectively operate a motorized wheelchair during a two-month trial period
- The child's two- month trial period shows evidence that the use of the motorized wheel chair has enhanced the child's overall development including cognitive abilities, directionality, spatial perception and social skills such as independence and self-concept
- Other: \_\_\_\_\_

**OPTIONS/ACCESSORIES:**

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

<input type="checkbox"/> Adjustable arm rest option	<input type="checkbox"/> Arm trough	<input type="checkbox"/> Power tilt
<input type="checkbox"/> Power reclining wheelchair backs	<input type="checkbox"/> Swing away hardware	<input type="checkbox"/> Elevating leg rests
<input type="checkbox"/> Power elevating leg rests	<input type="checkbox"/> Safety belt	<input type="checkbox"/> Pelvic strap
<input type="checkbox"/> Chest strap	<input type="checkbox"/> Fully reclining back option	<input type="checkbox"/> Positioning seat cushion
<input type="checkbox"/> Positioning back cushion	<input type="checkbox"/> Positioning accessory	<input type="checkbox"/> Special interfaces/switches
<input type="checkbox"/> Transit options, tie downs	<input type="checkbox"/> Towing package	<input type="checkbox"/> Crutch and cane holder
<input type="checkbox"/> Gloves	<input type="checkbox"/> Cup holders	<input type="checkbox"/> Upgrading for racing or sports
<input type="checkbox"/> Firearm/weapon holder/support	<input type="checkbox"/> Frame/holder for ice chest	<input type="checkbox"/> Snow tires for the device
- Auto carrier
- Powered seat elevator attachments for electric-powered, or motorized assist devices
- Support frames for cellular phone/CDs/etc
- Mobility assistive device rack for automobiles
- Lifts providing access to stairways or car trunks
- Nonadjustable combination skin protection and positioning seat cushion
- Adjustable combination skin protection and positioning seat cushion
- Baskets/bags/backpacks/pouch used to transport personal belongings
- Trunk loader, assists in lifting the assistive device into a van
- Prefabricated plastic-frame back support that can be attached to the device that doesn't replace the back
- Ramps used to allow entrance or exit from home
- Prefabricated plastic or foam vest type trunk support designed to be worn over clothing and not attached to device
- Van modifications, van lifts, hand controls, etc. that allow transportation or driving while seated in the power wheeled mobility device
- Request is for a second backup battery/charger (initial battery/charger is included in a power wheelchair base)
- Other: \_\_\_\_\_

- The options or accessories are necessary for the member to function in the home and perform the activities of daily living
- An option/feature which exceeds that which is medically necessary to treat the member's condition
- Power wheeled mobility devices/options not related specifically to the individual'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 arms and 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 cannot reposition self, cannot operate a manual tilt and left alone most of the day
- 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.
- Power elevating leg rests for the individual who cannot operate manual leg rests
- The member has weak upper body muscles, upper body instability or muscle spasticity which requires the use of this item for proper positioning
- The member spends at least 2 hours per day in the assist device and there is need to rest in a recumbent position two or more times during the day and 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)
  - quadriplegia
  - paraplegia
  - multiple sclerosis
  - other demyelinating disease
  - cerebral palsy
  - post polio paralysis
  - spina bifida
  - childhood cerebral degeneration
  - Parkinson's disease
  - monoplegia of the lower limb
  - hemiplegia due to stroke
  - traumatic brain injury
  - muscular dystrophy
  - torsion dystonias
  - spinocerebellar disease
  - anterior horn cell diseases including amyotrophic lateral sclerosis
  - traumatic brain injury resulting in quadriplegia
  - Other: \_\_\_\_\_
- 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
- Special interfaces/switches are requested since the member has no upper body movement to control the vehicle with breath (sip and puff), head movement, touch and voice

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.**