

CG

**CERTIFICATE OF MEDICAL NECESSITY**

**MANUAL WHEELCHAIRS**

<b>SECTION A Certification Type/Date:</b> INITIAL <u>  </u> / <u>  </u> / <u>  </u> REVISED <u>  </u> / <u>  </u> / <u>  </u>	
PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER  (____) _____ HICN _____	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER <b>INDEPENDENT LIVING AIDS of GEORGIA</b> 6002 Veterans Parkway Columbus, GA 31909 Fax: (706) 327-2099 (706) 327-5613 NSC # 1149340001
PLACE OF SERVICE _____ NAME and ADDRESS of FACILITY if applicable (See Reverse)	HCPCS CODE _____ _____ _____ _____
PT DOB <u>  </u> / <u>  </u> / <u>  </u> ; Sex <u>  </u> (M/F); HT. <u>  </u> (in.); WT. <u>  </u> (lbs.) PHYSICIAN NAME, ADDRESS, TELEPHONE and UPIN NUMBER  (____) _____ UPIN # _____	

**SECTION B Information in This Section May Not Be Completed by the Supplier of the Items/Supplies.**

EST. LENGTH OF NEED (# OF MONTHS): <u>  </u> 1-99 (99=LIFETIME)		DIAGNOSIS CODES (ICD-9): <u>  </u>
ITEM ADDRESSED	ANSWERS	ANSWER QUESTIONS 1, 5, 8 AND 9 FOR MANUAL WHEELCHAIR BASE, 1-5 FOR WHEELCHAIR OPTIONS/ACCESSORIES. (Circle <b>Y</b> for Yes, <b>N</b> for No, or <b>D</b> for Does Not Apply, unless otherwise noted.)
Manual Whichr 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. Whichr	_____	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. Whichr	Y N D	8. Is the patient able to adequately <u>self-propel</u> (without being pushed) in a standard weight manual wheelchair?
Any Type Ltwt. Whichr	Y N D	9. If the answer to question #8 is "No," would the patient be able to adequately <u>self-propel</u> (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.

ITEM	HCPCS CODE	QTY	DESCRIPTION OF EQUIPMENT	SUPPLIER'S CHARGE	MEDICARE ALLOWANCE
A	K0004RR	1	High Strength Lt Wt Manual W/C	\$ 110.00	\$ 108.35
B	K0031NU	1	Safety Belt	\$ 41.00	\$ 40.73
C	K0021NU	2	Anti-Tippers	\$ 62.71	\$ 62.71
D	K0963NU	1	2" Seat Cushion	\$ 66.23	\$ 66.23

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)