

Physician Statement of Medical Necessity for a Power Operated Wheelchair

CG(web)

REFERENCE: _____ DATE: ___/___/___
HICN: _____

I filled out a **Certificate of Medical Necessity** for the above referenced patient. I also understand that there is further documentation needed for **Medicare** to cover the **“Power Wheelchair.”** This statement is to further document the need of my patient.

1.) The diagnoses that are responsible for my patient’s problems with ambulation are:

2.) My patient is able to walk ____ feet / steps (*Circle one*)

3.) My patient is **unable** to use a *manual wheelchair, cane, or walker* in their home for the following reason(s): _____

4.) Other pertinent information that describes my patient’s functional abilities and limitations and their need for a “Power Wheelchair” are the follows: _____

Sincerely,

X _____