Indiana Health Coverage Programs

Medical Clearance for Nonmotorized Wheelchair Purchase

Member Name: _____ **RID:** _____

Primary and Secondary Diagnoses: _____ **Length of illness:** _____

Height: **Weight:**

405 IAC 5-19-9 (a) – Medicaid reimbursement is available for wheelchairs or similar motorized vehicles, subject to the restrictions in this section, and requires prior authorization. (c) Requests for wheelchairs or similar motorized wheelchairs require a completed medical clearance form submitted with the prior authorization request before the request shall be reviewed.

1. Does the member currently have a wheelchair? What brand and model?
2. What is the condition of the current chair?
3. Why is this chair no longer effective for this member? Explain
4. Can it be repaired? Estimated cost? Will this chair be a second chair for this person?

Functional Status

Please provide the functional status of the member that warrants the use of the wheelchair and accessories.

1. Upper extremities (be specific)
2. Lower extremities (be specific)
3. Hand function (be specific)
4. Contractures (be specific)
5. Neck/spine (be specific)
6. Static/dynamic sitting balance (be specific)
7. Ambulation (be specific)
8. Transfer/bed mobility (be specific)
9. Activities of daily living (ADLs) (be specific)
10. Medical problems that require special positioning equipment (be specific)
11. Other

The provider may submit an Occupational Therapy or Physical Therapy evaluation if the above information is not sufficient for review.

Residence

Where does the member reside? ◯ Home ◯ Group Home ◯ Nursing Facility ◯ ICF/IID

Nursing Facility or ICF/IID

405 IAC 5-19-3 (b) DME and associated repair costs for the usual care and treatment of members in long term care facilities are reimbursed in the facility's per diem rate and may not be billed to Medicaid by the facility, pharmacy, or other provider. Nonstandard or custom/special equipment and associated repair costs require prior authorization by the office, and may be billed separately to Medicaid, when authorized.

1. If the member resides in a nursing facility or ICF/IID, what modifications are currently on the *per diem* wheelchair or previously used on the *per diem* wheelchair to improve the member's function?

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2. If these modifications to the *per diem* wheelchair failed, please explain why.

3. If no modifications were added to the *per diem* wheelchair, please explain why.

Wheelchair Specifications

1. Specify the brand and model of the requested wheelchair.
2. What are the special features of the above-mentioned wheelchair that are needed by the member?

Special Feature	Body Measurements	
a. Hemi height	Knee to heel	_____
b. Seat depth	Femur length	_____
c. Seat width	Hip width	_____
d. Other		_____

Wheelchair Accessories

List the accessories needed to make this wheelchair functional for the member and the corresponding problem that will be corrected or will be prevented from worsening. Use an additional page if more items need to be listed.

Accessory	Member Specific Problem Corrected

Comments:

Signature and Title _____ **Date** _____