DEPARTMENT OF HEALTH & HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0679
DMERC 02.03A

CERTIFICATE OF MEDICAL NECESSITY

MOTORIZED WHEELCHAIRS

SECTION A **Certification Type/Date:** INITIAL ___/___/___ REVISED ___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER
(___)___-____ HICN ___	(___)___-____ NSC # ___
PLACE OF SERVICE ___ NAME and ADDRESS of FACILITY if applicable (See Reverse)	HCPCS CODE ___ ___ ___ ___
	PT DOB ___/___/___; Sex ___ (M/F); HT.___(In.); WT.___(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): 99 1-99 (99=LIFETIME) DIAGNOSIS CODES (ICD-9): ___ ___ ___ ___

ITEM ADDRESSED	ANSWERS	ANSWER QUESTIONS 1, 6 AND 7 FOR MOTORIZED WHEELCHAIR BASE, 1-5 FOR WHEELCHAIR OPTIONS/ACCESSORIES. (Circle Y for Yes, N for No, or D for Does Not Apply, unless otherwise noted.)
Motorized Whlchr 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 Height Armrest	___	5. How many hours per day does the patient usually spend in the wheelchair? (1–24) (Round up to the next hour)
Motorized Whlchr Base	Y N D	6. Does the patient have severe weakness of the upper extremities due to a neurologic, muscular, or cardiopulmonary disease/condition?
Motorized Whlchr Base	Y N D	7. Is the patient unable to operate any type of manual wheelchair?

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.

☐ 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)

FORM HCFA 843 (5/97)

Mobility Assistive Equipment – Face to Face Examination Report

Patient Information

Name					
Mailing Address:					Medicare (HICN)#:
City:	State:	Zip:	DOB:	Age:	Telephone:
					SSN:

Physician or Treating Practitioner Information

Name:					
Mailing Address:					Date of Last Visit:
City:					Telephone:
				State:	Zip:

Current Symptoms, Related Diagnoses, and History

Please describe the reason for this mobility evaluation

Please list previously diagnosed conditions that relate to the current office visit

Physical Exam

Ht:	Wt:	B/P:	Pulse (resting):	Respiratory: Normal Labored at times Is O_2 required? Y N

Any current pressure sores? Y N Location: _____

Poor Balance: Y N History or Risk of Falls: Y N Poor Endurance: Y N

Cachexia (severe weakness): Y N Obesity: Y N Significant Edema: Y N

Holds to furniture/walls for mobility Y N

Neck, Trunk and Pelvic Posture and Flexibility ____ Good ____Limited ____Severely Limited

Mobility Assistive Equipment – Face to Face Examination Report

Functional Assessment

	Question	Your Answers below must be justified by your narrative responses.	
1.	Does your patient have a mobility limitation that impairs participation in Mobility Required Activities of Daily Living (MRADLs) in the home? If YES, why:_____	☐ YES	GO TO QUESTION 2
		☐ NO	STOP – NO MAE
2.	Can their limitations be compensated by the addition of MAE to improve the ability to participate in MRADLs in the home? If YES, why:_____	☐ YES	GO TO QUESTION 3
		☐ NO	STOP – NO MAE
3.	Is your patient or their caregiver capable and willing to operate the MAE safely in the home?	☐ YES	GO TO QUESTION 4
		☐ NO	STOP – NO MAE
4.	Can their mobility deficit be safely resolved by a cane or walker? If NO, why:_____	☐ YES	STOP – ORDER CANE OR WALKER
		☐ NO	GO TO QUESTION 5
5.	Does your patient's home environment support use of a wheelchair or POV? (Home assessment to be completed by Medical Equipment Supplier)	☐ YES	GO TO QUESTION 6
		☐ NO	STOP – NO MAE
6.	Does your patient have the upper extremity function to safely propel a manual wheelchair to participate in MRADLs in the home? If NO, why:_____	☐ YES	STOP – ORDER MANUAL WHEELCHAIR
		☐ NO	GO TO QUESTION 7
7.	Does your patient have sufficient strength and trunk stability to operate a POV in the home? Please Explain:_____	☐ YES	GO TO QUESTION 8
		☐ NO	GO TO QUESTION 9
8.	Is your patient able to safely maneuver a POV in their home?	☐ YES	STOP – ORDER POV
		☐ NO	GO TO QUESTION 9
9.	Does your patient need the additional features (i.e. optimal maneuverability, ease of use, upgradeable/adaptable seating, etc.) of a power wheelchair to participate in MRADLs in the home? If YES,why:_____	☐ YES	GO TO QUESTION 10
		☐ NO	STOP – NO MAE
10.	Is your patient safe and able to maneuver a power wheelchair in the home?	☐ YES	STOP – ORDER PWC
		☐ NO	STOP

The information provided is a true and accurate representation of my patient's current condition. I hereby incorporate this document into my patient's medical record. This document is supported by additional medical records in my patient's file.

Physician or Treating Practitioner Signature: _____ **Date:** _____