Tri-State Medical Supply LLC
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Power Wheelchair

Face to Face Evaluation Form

Patient Name: _____ DOB: _____

Address: _____

Phone: _____ Insurance: _____

Policy #: _____

Date of Face-to-Face Evaluation: _____

Please describe the reason for this mobility evaluation:

_____

_____

_____

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_____

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

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The face-to-face evaluation supports the beneficiary's condition meets all LCD coverage criteria:

1. The beneficiary has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADLs) in the home? (Please explain)

2. Use of a power wheelchair will significantly improve the beneficiary's ability to participate in MRADLs in the home? (Please explain why)

3. The mobility deficit cannot be sufficiently and safely resolved by the use of an appropriately fitted cane or walker.

4. The beneficiary does not have sufficient upper extremity function to self-propel an optimally configured manual wheelchair in the home to perform MRADLs during a typical day?

5. The beneficiary has a physical and/or mental limitation that prevents safe use of a POV in the home and/or the beneficiary's home provides inadequate access for operation of a POV?

6. The beneficiary has the mental and physical capabilities to safely operate the power wheelchair that is provided, or the beneficiary has a caregiver who is unable to adequately propel an optimally configured manual wheelchair, but is available, willing, and able to safely operate the power wheelchair that is provided?

7. The beneficiary's weight is less than or equal to the weight capacity of the PWC that is provided?

8. The beneficiary has not expressed an unwillingness to use a PWC in the home?

Physician Information:

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 Phone: _____ Fax: _____

Physician Name: _____ NPI: _____

Physicians Address: _____

Physicians Signature: _____ Date: _____