LTC Wheelchairs

Positioning & Mobility for Seniors

"The Wheelchair Experts"

5200 West 78th Street
Bloomington, MN 55435
Phone: (952)941-6800
Fax: (952)941-6006

Durable Medical Equipment Prescription

Patient Name:_____ Date Of Birth:_____

Address:_____

Physician Name:_____

Diagnosis/ICD-9 codes:_____

Length of Need: _____ Lifetime _____ # of Months Height:_____ Weight:_____

A Power Wheelchair HCPCS : K0822/K0823 Mid wheel power chair is covered if:

Criteria A,B,C,D,E,F,G and H are met. Additional coverage criteria for specific devices are listed below.

Section A The patient has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADL'S) such as toileting, feeding, dressing, grooming and bathing in customary locations in the home. A mobility limitation is one that: 1) Prevent the patient from accomplishing an MRADL entirely, or 2) Places the patient at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL; or 3) Prevents the patient from completing an MRADL within a reasonable time frame (Describe ADL status)_____ _____	Initial all that apply _____ _____ _____ _____
Section B The patient's mobility limitation **cannot** be sufficiently resolved by the use of an appropriately fitted cane or walker (Describe ambulation status)_____ _____	_____
Section C The patient's home provides adequate access between rooms, maneuvering space and surfaces for use of the manual wheelchair that is provided	_____
Section D Use of the power wheelchair will significantly improve the patient's ability to participate in MRADLs and the patient will use it on a regular basis in the home	_____
Section E The patient has not expressed an unwillingness to use the power chair in the home and has the mental and physical capabilities to safely operate the power chair	_____

LTC Wheelchairs 5200 W 78th St Bloomington, MN 55435 ph:(952) 941-6800 f: (952 941-6006)

Patient Name_____ Date of Birth_____

Section F a) The patient 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 b) The patient has U/E limitations of strength, endurance, range of motion, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function due to diagnosis of: (Circle all that apply)Weakness, Rotator Cuff Injury, CVA, COPD, Arthritis, Explain:_____ _____	_____
Section G If the beneficiary is unable to safely operate the power chair, the beneficiary has a caregiver who is available, willing and able to provide assistance with the power wheelchair due to inability to adequately propel an optimally configured manual wheelchair	_____
Section H a) The patient is unable to transfer to/from a POV/Scooter b) The patient is unable to operate the tiller c) The patient is unable to maintain postural stability while operating the POV/Scooter in the home d) The beneficiary's weight is less than or equal to the wt cap of the power chair provided	_____ _____ _____ _____

Assessment of Need:(Include home situation, physical limitation and mental capabilities):

_____

_____

_____

_____

Recommendation: ☐ Mid Wheel Power chair with van seat K0823 ☐Mid Wheel Power Chair with rehab seat K0822

☐☐Elevating Legrest R L ☐☐Footrest R L ☐ Footboard ☐Adj. Ht Arms E0973 ☐ U1 Gel batteries E2365

☐General Purpose Cushion E2601 ☐Skin Protection Cushion E2607 ☐General Purpose Back E2611

☐20"-22" Seat Width E2201 ☐24" Seat Width E2202 ☐Other_____

Therapist/Nurse Initials and Printed Name: _____

Therapist/Nurse Signature:_____Date:_____

Prescribing Physician(Print Name)_____

Prescribing Physician's Signature: _____Date:_____

Please fax this form back to LTC Wheelchairs at (952)941-6006