Southern Mobility and Medical

ACHC Accredited – Authorized Medicare & Preferred BCBS Provider
Phone 1-800-681-8831 Fax 1-877-611-3500

General Insurance Guidelines For a Power Wheelchair

(for most BCBS plans including PPO, PFFS and Federal)

Dear Physician,

Please find attached the power chair documentation instructions for BCBS insurance. If you feel that your patient would benefit from a power chair for in-home mobility, please provide the following two (2) items below.

1. **Please complete the attached Prescription form(s) and return it along with:**

2. **A letter of Medical Necessity explaining the patient's needs for this equipment, according to the enclosed guidelines.**

Please fax these documents, along with patient demographics, to us at 1-877-611-3500 or call with any questions at 1-800-681-8831.

Thank you for your time and assistance.

PHYSICIAN:

Name:_____
Address:_____
City, State_____
Zip Code:_____

PRESCRIPTION

Patient's Information: _____ **DOB:** _____

Height:_____ Weight:_____

Medical Necessity: For the reasons indicated below it is medically necessary for the above referenced patient to have the following medical equipment for use in the home:

1. Motorized Wheelchair
2. Accessories (see separate page)

1. **Diagnosis and ICD10 codes:**
   _____

   _____

2. **Degree:** ☐ Slight ☐ Moderate ☐ Severe

3. **Prognosis:** ☐ Stable ☐ Erratic ☐ Progressive ☐ Degenerative

4. **Justification:** ☐ Patient is unable to ambulate without assistance

5. **The patient is unable to safely operate a manual wheelchair due to:**
   ☐ Patient has weakness of hands and/or upper extremities
   ☐ Patient lacks coordination of upper extremities
   Other:_____

6. **Estimated Length of Need:** *Equipment will be needed for*
   ☐ Lifetime ☐ 24 Months or more

_____ _____ _____

Physician's Signature **NPI** **Date**

PRESCRIPTION

Patient: _____ DOB: _____

The Following Accessories for the Motorized Wheelchair

	JUSTIFICATION
_x_ Batteries & Battery Charger	Required Power Source
_x_ Anti-Tip Devices	To Prevent Injury from Tipping
_x_ Adjustable Hgt. Armrests (Detachable)	To Support arms and shoulders and maintain their proper height and to facilitate transfer.
_x_ Headrest	To support Neck & Head
_x_ Safety Belt positioning	To maintain proper and Safety
_x_ Adjustable Footrest	For balance and customized foot and leg positioning
_x_ Suspension System	For safer operation over different surfaces or thresholds
_x_ Retractable Joystick	For slide transfers
Additional options if marked:	
___ Elevating Leg rests	Edema
___ Extra Wide Seat	20”+ Seat width
___ Oxygen tank holder	Portability of O2

_____ _____ _____

Physician's Signature **NPI** **Date**

Southern Mobility and Medical
Phone: (800) 681-8831 Fax: (877) 611-3500

PHYSICIAN GUIDELINES FOR COMPLETING LETTER OF MEDICAL NECESSITY

If you agree that a power chair is medically necessary for in-home use and consistent with your course of treatment, please use the following as an outline and address each item in an objective narrative to paint a picture of the patient's daily ambulation difficulties.

Please Detail all of the Following Information in a Letter of Medical Necessity, on your Letterhead:

1. Describe the patients' medical conditions and the extent of the physical limitations with regards to ambulation.
2. Describe at least 2-3 specific indoor mobility related daily living activities (MRDLA)*that the patient has difficulty completing
   (*MRDLA's consist of toileting, dressing, grooming, meal preparation, home management, etc.)
3. Please list the type of device the patient is currently using and why it will not resolve their ambulation difficulties in the home.
4. Please explain why a cane will not resolve their condition. Clarify with specific medical conditions.
5. Please explain why a walker will not resolve their condition. Clarify with specific medical conditions.
6. Explain why the patient cannot propel a manual wheelchair to complete ADL's. Clarify with specific medical conditions.
7. Note why a power wheelchair is recommended over a scooter: (i.e. indoor maneuverability, joystick controller vs. a steering tiller for less upper body exertion, or slide transfers).
8. If applicable, mention if the patient has a risk of injury due to falling or loss of balance.
9. Indicate patient's upper and lower extremity strength (____/5)
10. As applicable, please provide a numeric rating with your scale to rate the patient's overall pain level, range of motion, and endurance level.
11. Explain how the use of a Motorized Wheelchair will improve the patient's ability to perform MRDLA's?
12. Mention the patient's willingness and capability to safely operate a motorized wheelchair in the home

Please fax LMN and Rx to 1-877-611-3500 or call
1-800-681-8831 with any questions.

PATIENT: _____ DOB: _____