

Power Mobility Device Questionnaire Form

Submit completed form via fax to 1-833-263-4869 or email PriorAuth@MediGold.com.

General Information

Today's Date: _____

| | |
|-----------------------|-------------------------|
| Member's Name | Member's ID Number |
| Member's Address | Member's Phone Number |
| Gender | Date of Birth |
| Provider's Name | Provider's Phone Number |
| Provider's TIN Number | Provider's NPI Number |

Diagnosis

Equipment
 Electric Wheelchair Motorized Scooter

Has the patient had a face to face examination in the last 45 days?
 Yes No

Does the patient have mobility related ADLs that cannot effectively be performed in the home using a cane, walker or manually operated wheelchair?
 Yes No

Does the patient have a personal mobility deficit sufficient to impair the performance of mobility related ADLs such as toileting, feeding, dressing, grooming and bathing in customary locations in the home?
 Yes No

Does the home have adequate modifications for usage?
 Yes No

Is the length of time needed greater than 90 days?
 Yes No

Need for further customization:

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?
 Yes No

Does the patient have a need for arm height different than available using non-adjustable arms?
 Yes No

Additional comments:

Power Mobility Device Questionnaire Form

| | |
|---|---|
| Member's Name | Member's ID |
| Physician's Signature | |
| Denied <input type="checkbox"/> | Approved <input type="checkbox"/> |
| Vendor | Equipment <input type="checkbox"/> Electric Wheelchair <input type="checkbox"/> Motorized Scooter |
| Authorization Number | Date Span |

IN ADDITION TO COMPLETING THIS FORM, PRIOR AUTHORIZATION MUST ALSO BE OBTAINED

Member must be notified of appropriate coinsurance

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