UniCare

Wheelchair

Precertification-Clinical Worksheet
Phone: 800-442-9300 / Fax: 800-848-3623

Patient name: _____ DOB: _____ Member ID: _____

Provider: _____

Provider address: _____

Provider phone: _____ Provider fax: _____ Provider NPI #: _____

Requesting physician: _____

Physician address: _____

Physician phone: _____ Physician fax: _____ Physician NPI #: _____

Equipment start date: _____ New: _____ Used: _____

Rental or purchase? _____

Notification #: _____

In order to review the medical necessity for this service, we need the following information:

- Prescription for the requested durable medical equipment
- Documentation of medical necessity
- Replacement equipment requires documentation of disrepair / out of warranty

Relevant diagnosis and past medical history (related to wheelchair): _____

_____

Functional status:

1. Is the patient able to ambulate to safely complete ADLs? ___Yes ___No
   If yes, approximate distance: _____
2. Does the environment / home support the use of a wheelchair? ___Yes ___No
3. Was a physical therapy or occupational therapy assessment completed? ___Yes ___No
   If yes, date of assessment: _____ Results: _____
4. Does the patient have stamina to wheel self? ___Yes ___No
5. Approximate length of time in chair per day _____hours/day
6. The patient is willing and able to consistently operate the powered/motorized wheelchair or POV safely and effectively ___Yes ___No
7. The patient is unable to operate a *manual* wheeled mobility device ___Yes ___No
8. The patient's medical condition requires a powered/motorized wheelchair or POV device for long-term use of at least six months to one year ___Yes ___No
9. The powered/motorized wheelchair or POV is ordered by the physician responsible for the patient's care ___Yes ___No
10. Where does the patient reside? ___Own home ___SNF ___Other (specify) _____
    If home, does patient live alone? ___Yes ___No
11. How long will the patient require the wheelchair?
    # of weeks_____ # of months_____ Indefinite _____

Type of wheelchair with HCPC codes and prices (specify):

Type: _____HCPC _____ Purchase $ _____Rental $ _____

Attachments: _____HCPC _____ Purchase $ _____Rental $ _____

_____HCPC _____ Purchase $ _____Rental $ _____

Other: _____HCPC _____ Purchase $ _____Rental $ _____

UniCare has preferred providers for DME services. To get the maximum benefit, a preferred provider must be used. UniCare covers the allowed rental charge up to the allowed purchase price for approved durable medical equipment.

Signature:_____ **Date**: _____

Print name:_____ **Phone**: _____

After completing this form and obtaining the necessary clinical information, please fax to 800-848-3623.