Clear Form Data
FILLABLE FORM

DHS-4315-ENG 10-08

Minnesota Department of **Human Services**

Authorization Request for Mobility Devices

NOTE: Refer to the MHCP Provider Manual for coverage policy. If more space is needed, continue answer on a separate piece of paper and indicate which question you are answering. If coverage policy requires a PT/OT exam, attach documentation of that exam to this form.

PATIENT'S LAST NAME	FIRST NAME	MI
MHCP RECIPIENT ID #	DATE OF BIRTH	

1. Patient's Diagnosis: ICD-9 Code _____ Description _____

2. Height _____ Weight _____ Other information regarding size/stature _____

3. Patient's current living arrangement and extent of ADL assistance required:
   Living Arrangement: ☐ Home ☐ Nursing Facility ☐ Group Home ☐ Assisted Living ☐ ICF/MR
   ADL Assistance Required: ☐ All, totally dependent ☐ Some, partially dependent ☐ None, independent

4. Does the patient require assistance for activities of daily living? List and describe their ability and who is the caregiver providing the assistance?

   A. Does patient have PCA services? ☐ Yes ☐ No _____ # of hours/day.
   B. How many hours a day is the patient alone? _____ # hours/day.
   C. Describe PCA responsibilities.

5. If the patient is in a hospital, nursing facility, or board and care, what is the specific discharge plan or description of unusual medical need?

6. Mobility device requested: ☐ Power ☐ Manual
   Make _____ Model _____

7. Give a complete description of the patient's medical condition and the medical necessity for the requested equipment. What mobililty related activities of daily living is the patient unable to perform and how will the mobility device allow the patient to perform those ADLs. Include any complicating previous or present physical conditions (e.g., skin breakdown, pain, contractures).

8. Scooter required. Explain why a manual wheelchair would not meet the patient's needs: (e.g., exertion scale rating, distances patient can self propel). How far can the patient independently ambulate? Can the patient safely operate the scooter? Can the patient safely transfer in and out? Does the patient have adequate trunk stability to ride safely in the scooter? How will the patient transport the scooter?

9. Power wheelchair required. Explain why a scooter would not meet the patient's needs:

10. Where will the wheelchair/scooter be used, and the approximate duration at each location (hrs/day and days/wk)? On what types of surfaces will the chair be used?

11. Patient's roles and responsibilities; in the community, at work, and at home:

12. Explain how the patient has adequate judgment, maturity and skill to safely operate this wheelchair/scooter in all environments, including crowded situations.

13. Trials of requested equipment in the patient's home, school, work, and community environments, etc., to assure it will meet the patient's needs, and fit in all areas of the patient's home. Document the outcome of the trial, including an assessment of the accessibility of the home and all other necessary environments.

Is there a ramp? ☐ Yes ☐ No Are there stairs? ☐ Yes ☐ No Is there an elevator? ☐ Yes ☐ No

If provider does not have a wheelchair for patient to trial, DHS does pay for rental up to 3 months, without an authorization. NOTE: Rental will be deducted from the purchase price, unless extenuating circumstances can be proven.

14. How will the equipment be transported? _____

Was the equipment transported during the trial period? ☐ Yes ☐ No

Does the equipment fold or disassemble easily for transport? ☐ Yes ☐ No

Does the equipment fit into the family vehicle? ☐ Yes ☐ No

15. List all less costly alternatives and explain why that equipment will not meet the patient's medical needs. Provide cost comparison of comparable mobility devices and thoroughly document the reasons why less costly alternatives will not meet the patient's needs.

16. If requesting a group 4 power wheelchair, explain why a group 3 PWC would not meet the patient's needs. If requesting a group 3 power wheelchair, explain why a group 2 PWC would not meet the patient's needs.

17. Does the patient require: (check all that apply, list medical necessity and least costly alternative for each)
    - ☐ Power elevating leg rests (explain) _____
    - ☐ Reclining back feature (explain) _____
    - ☐ Tilt option (explain) _____
    - ☐ Non-standard seat width (explain) _____
    - ☐ Non-standard seat depth (explain) _____
    - ☐ Power seat elevator (explain) _____
    - ☐ Attendant Control (explain) _____

18. List all other requested accessories that require authorization or pricing and the medical necessity of each:

Description	**Medical Necessity**

19. List the patient's current mobility equipment, age of equipment, make, and model. Describe why this chair is no longer meeting the patient's medical needs. **If current chair is being replaced due to extensive repairs, give estimates on repairs needed.**

    _____

    _____

    _____

20. Approximate length of time needed: (purchase or rental) _____

    (If the need for a wheelchair is permanent, wheelchair rental is not appropriate and the authorization request should be for purchase).

Attach manufacturer's quote, price list or invoice to the request for authorization for manual pricing. Do not modify, alter or change the pricing documentation. Do not block out any information on the pricing documentation.

NAME OF COMPANY	NPI
SIGNATURE OF EQUIPMENT SPECIALIST	DATE
SIGNATURE OF PT/OT/OTHER PROFESSIONAL INVOLVED IN EVALUATION AND CREDENTIALS	DATE
SIGNATURE OF PHYSICIAN VERIFYING INFORMATION	DATE
ADDRESS OF PHYSICIAN	PHONE NUMBER ( )

Wheelchair providers return completed form and authorization request to:

CDMI (Care Delivery Management, Inc.)
PO Box 64265, R3-49
St. Paul, MN 55164-0560

FAX: (651) 662-7459