



**Utilization Management**  
**Phone No.: 1-877-284-0102      Fax No.: 1-800-510-2162**

HealthLink Durable Medical Equipment—Custom Wheelchair/Electric Scooter Pre-Review

**DME review is required for rental or purchase that will be greater than \$1000**

Date: \_\_\_\_\_ Notification # \_\_\_\_\_ (provided after initial review)  
*A Utilization Management representative will fax you a notification number by the next business day after receiving this completed form. This notification number does not indicate an approval or denial of benefits, but only proof that the Plan has been notified. This information will be forwarded to the Plan's Managed Care department. If you have any questions, please call Healthlink at 1-877-284-0102.*

**Provider Information**

Provider's Name: \_\_\_\_\_  
Address \_\_\_\_\_  
Phone No. \_\_\_\_\_ Fax No. \_\_\_\_\_

**Patient Information**

Patient's Name \_\_\_\_\_  
ID Number \_\_\_\_\_ Patient's DOB: \_\_\_\_\_  
Address \_\_\_\_\_  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Daytime Phone No. \_\_\_\_\_

**Ordering Physician Information**

Physician's Name \_\_\_\_\_  
Address \_\_\_\_\_  
Phone No. \_\_\_\_\_ Fax No. (Required) \_\_\_\_\_  
TIN: \_\_\_\_\_

**Treatment Information**

Diagnosis & Past Medical History (related to wheelchair): \_\_\_\_\_  
\_\_\_\_\_

Is the patient able to ambulate? Yes  No  if **yes**, approximate distance \_\_\_\_\_

Does the patient have stamina to wheel self? Yes  No

Approximate length of time in chair per day: \_\_\_\_\_ hrs per day

Where does the patient reside? Home  SNF  Other  (specify) \_\_\_\_\_  
If home, do they live alone? Yes  No

Equipment Start Date \_\_\_\_\_ New  Used

How long will the patient require custom wheelchair/electric scooter?  
# \_\_\_\_\_ Weeks # \_\_\_\_\_ Months \_\_\_\_\_ Indefinite

\*Type of custom wheelchair/electric scooter with HCPC code and prices:

	<b>Specify</b>	<b>HCPC</b>	<b>Purchase</b>	<b>Rental</b>	<b>Circle One</b>
<b>Type</b>			\$	\$	per D / W / M
<b>Attachment(s)</b>			\$	\$	per D / W / M
<b>Attachment(s)</b>			\$	\$	per D / W / M
<b>Other</b>			\$	\$	per D / W / M

**Contact Information**

Contact Person \_\_\_\_\_  
 Phone No. \_\_\_\_\_ Fax No. \_\_\_\_\_

Staff Signature/Title: \_\_\_\_\_ Date: \_\_\_\_\_

*\*The Plan has a preferred provider for DME Services. In order to receive the maximum benefit, the preferred provider must be used.*

Benefits depend upon the eligibility of the patient at the time of admission, subject to all other Plan limitations, pre-admission review requirement and prior related claims. Verification of eligibility and description of benefits are based upon the information we have on file and does not guarantee payment.