Utilization Management
Phone: 1-877-284-0102 Fax: 1-800-510-2162

Durable Medical Equipment – Custom/Power Wheelchair/Electric Scooter Precertification Review

Date: _____ Reference #: _____(provided after initial review)
A Utilization Management representative will fax you a reference number by the next business day after receiving this completed form. This reference 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

Name: _____

Address: _____

Phone: _____

Fax: _____

Patient Information

Patient Name: _____

ID Number: _____

Patient DOB: _____

Address: _____

Phone: _____

Ordering Physician Information

Physician Name: _____

Address: _____

Phone: _____

Fax: _____

TIN: _____

Treatment Information

Pertinent Medical History (submit history related to wheelchair): _____

_____

_____

Primary Diagnosis: _____

Diagnosis (ICD-10) Code: _____

Primary Procedure: _____

Procedure (ICD-10) Code: _____

Is the patient able to ambulate? ☐ YES ☐ NO

If yes, approximate distances: _____

Can patient safely and effectively use the wheelchair in the home setting to complete ADL's? ☐ YES ☐ NO

Can other assistive devices (canes, walkers, manual wheelchairs) be used to meet functional mobility needs?

☐ YES ☐ NO

Where does the patient reside? ☐ Home ☐ SNF ☐ Other, please specify _____

If home, do they live alone? ☐ YES ☐ NO

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.

Does the patient's living environment support the use of a manual wheelchair? ☐ YES ☐ NO

Is the patient able and willing to consistently operate the wheelchair safely and effectively? ☐ YES ☐ NO

Does the patient have stamina to use a manual wheelchair? ☐ YES ☐ NO

Approximate length of time in chair per day: _____hrs per day

Equipment Start Date: _____

Is the equipment: ☐ New ☐ Used

How long will the patient require custom wheelchair/electric scooter? ____ Weeks ____ Months ____ Indefinite

*Please select the type of custom wheelchair/electric scooter:

☐ Standard Wheelchair ☐ Heavy Duty Wheelchair

☐ Lightweight Wheelchair ☐ Power/motorized Wheelchair

	HCPC	Purchase	Rental	Circle One
Type selected above		**$**	**$**	per day / week / month
Attachment(s)		**$**	**$**	per day / week / month
Attachment(s)		**$**	**$**	per day / week / month
Other		**$**	**$**	per day / week / month

Provider Contact Information

Contact Person: _____

Title: _____

Phone: _____

Fax: _____

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