GEORGIA DEPARTMENT OF COMMUNITY HEALTH

CERTIFICATION OF MEDICAL NECESSITY MANUAL WHEELCHAIR
PT/OT EVALUATION REQUIRED FOR MEMBERS UNDER 21

PT/OT evaluation requirement excludes members under twenty-one (21) years of age requesting a short-term rental.

Certification Type/Date: INITIAL _____/_____/_____ REVISED _____/_____/_____	
Members Name: _____	**Members Medicaid Number (Do Not List Mother's ID):** _____
Patient DOB_____/_____/_____ Sex_____ HT._____(in) WT._____(lbs.)	
Suppliers Name: _____ **Suppliers NPI Number:** _____	Suppliers Address and Telephone Number: _____ _____ _____
Physicians Name: _____ **Physicians NPI Number:** _____	Physicians Address and Telephone Number: _____ _____ _____
HCPCS Code(s)	
Place of Service	

Primary Diagnosis:_____ICD-10 Diagnosis Code_____

Secondary Diagnoses supporting medical necessity:_____

ICD-10 Diagnosis Code(s)_____ Length of Need_____

PHYSICAL EXAMINATION:

Provide detailed results of the physical examination as it relates to the member's mobility needs, and any related needs for special accommodations, options or accessories.

Ambulatory Status	Is the member ambulatory? ☐ YES ☐ NO If yes, describe in detail:
Amputation Status	Is the wheelchair necessary due to surgery or amputation? ☐ YES ☐ NO If yes, list the type of surgery and the date it was performed: _____ Date_____ Expected prognosis: _____ _____ _____

Patient Name:_____**DOB:**_____

CVA or Injury Status	Is this wheelchair necessary due to a CVA or injury? ☐YES ☐ NO If yes, what was the date of the CVA or injury? _____/_____/_____ Area affected by the CVA or injury include: _____ Describe the injury if applicable: _____ Describe limitations: _____
Prognosis	What is the member's potential for rehabilitation? ☐ GOOD ☐ FAIR ☐ POOR What is the member's prognosis? ☐ GOOD ☐ FAIR ☐ POOR
Activities of Daily Living	What are the member's activities of daily living that require the use of a wheelchair?
Wheelchair Specs	List the wheelchair specifications that are necessary and the justification for medical necessity (elevating footrests, detachable arms, extra-wide, light-weight, etc.) If and extra-wide wheelchair is prescribed, will the member's home (halls and doorways) accommodate the larger size wheelchair? ☐ YES ☐ NO

Ordering Physician

I certify that the manual wheelchair listed on this certificate is medically necessary for this member, and that I have had a face-to-face evaluation with this member to discuss and review the appropriateness of the device within the six (6) months preceding this order, and I am enrolled with Georgia Medicaid for the purpose of ordering, referring, or prescribing medical services.

Date of face-to-face evaluation _____/_____/_____ (Must have occurred within 180 days prior to the order date)

Physician's Signature _____Date_____/_____/_____

Stamps are not an acceptable form of authentication for the date or signature on a certificate of medical necessity or prescription/written order submitted to Georgia Medicaid.