U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0679

# CERTIFICATE OF MEDICAL NECESSITY

DMERC 02.03B

MANUAL WHEELCHAIRS

## SECTION A

Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___

| PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER | SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER |
|---|---|
| HICN _____ | NSC # |
| PLACE OF SERVICE _____<br>NAME and ADDRESS of FACILITY if applicable (See Reverse) | HCPCS CODE<br>_____<br>_____<br>_____<br>_____ |
| PT DOB / / Sex: (M/F) HT: (In) WT: (lbs) | |
| PHYSICIAN NAME, ADDRESS, TELEPHONE and UPIN NUMBER<br>UPIN # _____ | |

## SECTION B

Information in This Section May Not Be Completed by the Supplier of the Items/Supplies.

EST. LENGTH OF NEED (# OF MONTHS): _____ 1-99 (99=LIFETIME)

DIAGNOSIS CODES (ICD-9): _____ _____ _____ _____

| ITEM ADDRESSED | ANSWERS | ANSWER QUESTIONS 1, 5, 8 AND 9 FOR MANUAL WHEELCHAIR BASE, 1-5 FOR WHEELCHAIR OPTIONS/ ACCESSORIES. (Circle **Y** for Yes, **N** for No, or **D** for Does Not Apply, unless otherwise noted.) |
|---|---|---|
| Manual Whlchr Base And All Accessories | Y N D | 1. Does the patient require and use a wheelchair to move around in their residence? |
| Reclining Back | Y N D | 2. Does the patient have quadriplegia, a fixed hip angle, a trunk cast or brace, excessive extensor tone of the trunk muscles or a need to rest in a recumbent position two or more times during the day? |
| Elevating Legrest | Y N D | 3. Does the patient have a cast, brace or musculoskeletal condition, which prevents 90 degree flexion of the knee, or does the patient have significant edema of the lower extremities that requires an elevating legrest, or is a reclining back ordered? |
| Adjustable Height Armrest | Y N D | 4. Does the patient have a need for arm height different than that available using non-adjustable arms? |
| Reclining Back; Adjustable Ht. Armrest; Any Type Ltwt. Whlchr | _____ | 5. How many hours per day does the patient usually spend in the wheelchair? (1-24 ) (Round up to the next hour) |
| Any Type Ltwt. Whlchr | Y N D | 8. Is the patient able to adequately self-propel (without being pushed ) in a standard weight manual wheelchair? |
| Any Type Ltwt. Whlchr | Y N D | 9. If the answer to question #8 is "No," would the patient be able to adequately self-propel (without being pushed) in the wheelchair which has been ordered? |

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):
NAME: _____ TITLE: _____ EMPLOYER: _____

## SECTION C

Narrative Description of Equipment and Cost

**(1)** Narrative description of all items, accessories and options ordered; **(2)** Supplier's charge; and **(3)** Medicare Fee Schedule Allowance for each item, accessory, and option. (See instructions on back.) If additional space is needed, list wheelchair base and most costly options/accessories on this page and continue on HCFA Form 854.

| HCPCS | DESCIPTION | SUPPLIER CHARGE | MEDICARE FEE SCHEDULE |
|---|---|---|---|

☐ CHECK HERE IF ADDITIONAL OPTIONS/ACCESSORIES ARE LISTED ATTACHED HCFA FORM 854

## SECTION D

Physician Attestation and Signature/Date

I certify that I am the treating physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE _____ DATE ____/____/____ **(SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)**