CERTIFICATION FOR STANDARD WHEELCHAIR.

Alliant GMCF PA/UM
Department
PO Box 105329
Atlanta, GA 30346

All wheelchairs for recipients under the age of 21 require a PT or OT evaluation unless it is for short term rental.

Member Medicaid Number ____________________ Date of Birth ____________

Member Full Name ____

Diagnosis ___________________________________ICD-9 Code______________

*Weight ________________ *Height _______________ *Required

Describe ambulatory status in detail:____

____

Is this wheelchair necessary due to surgery or amputation? ☐YES ☐NO

If yes, what kind of surgery was done? _______________ Date of Surgery __________

Plans for prognosis____

Is a wheelchair necessary due to a CVA or injury? ☐YES ☐NO

If yes, what was the date of the CVA or injury? _________________

Areas affected by CVA or injury____

Describe the or injury____

Describe limitations____

What is the member's potential for rehabilitation? ☐GOOD ☐FAIR ☐ POOR

Prognosis ☐GOOD ☐FAIR ☐ POOR

What are the member's daily activities **that require the use of a wheelchair?**

____

What wheelchair specifications are necessary and why y are medically necessary (elevating foot rests, detachable arms extra wide, lightweight, etc.)?

____

If an extra-wide wheelchair is prescribed, will the member's home (halls and doorways) accommodate the larger size wheelchair? ☐YES ☐NO

How long will member need this equipment? ______________________________________

I CERTIFY THAT THIS WHEELCHAIR IS MEDICALLY NECESSARY:

Physician Signature ________________________________ Date ______________________

Address____

(Stamped signatures are not acceptable)