Medicaid



Montana Medicaid Certificate of Medical Necessity

Durable Medical Equipment (DME) and Supplies (Rev. October 2014)

Manual Wheelchair	
Patient Name, Address, Telephone Number, and Date of Birth Ph	ysician Name, Address, and Telephone Number
Medicaid ID Number NI	I Number
Diagnosis Height	Weight
Prognosis Esti	mated Length of Need (Months) 1–99 (99=Lifetime)
1. Does the patient currently own a wheelchair? Yes If yes, provide in	formation below. \Bigcup \text{No} \text{ If no, go to # 2.}
1a. Date of purchase.	The R no, go to # 2.
1b. Type of wheelchair. 1b.	
1c. Condition. 1c.	
1d. Original supplier of current wheelchair. 1d.	
1e. Repairs/modifications within last six months. 1e.	
2. Residence	
3. Does the patient require and use a wheelchair to move around in their residence? Yes No	
4. How many hours per day does the patient usually spend in the wheelchair? (1–24 hours; round up to the next hour.)	
5. Is the patient able to operate any type of manual wheelchair?	
6. Does the patient have the physical and mental ability to operate the requested wheelchair in a safe, controlled manner? \Bigsim Yes \Bigsim No	
7. Can the patient ambulate?	
8. Will the patient's home and transportation accommodate the requested wheelchair?	
9. Narrative description of all items, accessories, sizes and options to be included regarding this wheelchair. If additional space is needed, a continued narrative can be attached to this document as long as the pertinent patient and physician information is included at the top of the attachment. Physician's signature must also be included on the attached document).	
I certify that I am the treating physician identified in this form. I certify that the medical necessity information contained in this document and its attachments are true, accurate, and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material	
fact in this document may subject me to civil or criminal liability.	
Signature and date stamps are not acceptable.	
Physician's Signature	Date (mm/dd/yyyy)