

# Medicaid

## Montana Medicaid Certificate of Medical Necessity

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

<b>Motorized Wheelchair</b>		
<b>Patient Name, Address, Telephone Number, and Date of Birth</b>  Medicaid ID Number _____		<b>Physician Name, Address, and Telephone Number</b>  NPI Number _____
<b>Diagnosis</b>	<b>Height</b>	<b>Weight</b>
<b>Prognosis</b>		<b>Estimated Length of Need (Months) 1–99 (99=Lifetime)</b>
1. Does the patient currently own a wheelchair? <input type="checkbox"/> Yes <b>If yes, provide information below.</b> <input type="checkbox"/> No <b>If no, go to # 2.</b>		
1a. Date of purchase.	1a. _____	
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 <input type="checkbox"/> Home <input type="checkbox"/> Nursing Home <input type="checkbox"/> Hospital Rehab Unit <input type="checkbox"/> Institution <input type="checkbox"/> Group Home <input type="checkbox"/> Other _____		
3. Does the patient require and use a wheelchair to move around in their residence? <input type="checkbox"/> Yes <input type="checkbox"/> 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 unable to operate any type of manual wheelchair? <input type="checkbox"/> Yes <input type="checkbox"/> No		
6. Does the patient have the <b>physical</b> and <b>mental</b> ability to operate the requested wheelchair in a safe manner? <input type="checkbox"/> Yes <input type="checkbox"/> No		
7. Can the patient ambulate? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes, how and how far?</b> _____		
8. Will patient's home and transportation accommodate the requested wheelchair? <input type="checkbox"/> Yes <input type="checkbox"/> No		
9. Narrative description of <b>all</b> 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). <input type="checkbox"/> <b>Yes</b> , additional attachments <b>are</b> included. <input type="checkbox"/> <b>No</b> , additional attachments <b>are not</b> included.		
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.		
<b>Signature and date stamps are not acceptable.</b>		
_____ <b>Physician's Signature</b>		_____ <b>Date (mm/dd/yyyy)</b>