WHEELCHAIR LETTER OF MEDICAL NECESSITY

Patient Name: _____ Patient ID: _____

Prescribing Physician: _____

Physician's NPI Number: _____

Physician's Contact Information: _____

Medical Necessity Statement:

This letter is to certify that the patient named above has a qualifying medical condition that causes mobility limitations which significantly impair their ability to participate in mobility-related activities of daily living within the home and community. The prescribed wheelchair is medically necessary to enhance the patient's mobility and independence, promote health and safety, and prevent further deterioration or complications.

Diagnosis and Clinical Findings:

The patient has been diagnosed with the following conditions impacting mobility:

Primary Diagnosis: _____

Secondary Diagnosis (if any): _____

Relevant Clinical Findings: _____

Functional Limitations: _____

Wheelchair Prescription Details:

Based on the patient's medical condition and functional needs, the following wheelchair specifications are prescribed:

Type of Wheelchair (Manual/Electric): _____

Seat Width: _____

Seat Depth: _____

Seat Height: _____

Back Height: _____

Armrests (Type/Adjustability): _____

Footrests (Type/Adjustability): _____

Other Accessories Required: _____

Patient’s Functional Status and Mobility Needs:

The patient exhibits the following functional limitations and mobility needs that justify the wheelchair prescription:

Limited or no ability to walk: _____

Risk of falls or injury without wheelchair: _____

Need for mobility assistance inside and outside the home: _____

Ability to safely operate prescribed wheelchair: _____

Duration of Need:

The need for the prescribed wheelchair is anticipated to be:

Temporary: _____

Permanent/Long-Term: _____

Estimated duration (if temporary): _____

Additional Comments:

Please provide any additional clinical information or comments supporting the medical necessity of the prescribed wheelchair:

_____

_____

_____

_____

_____

Physician's Certification and Signature:

I hereby certify that the above information is true and accurate to the best of my knowledge, that the prescribed wheelchair is medically necessary for the patient named herein, and that this prescription complies with applicable federal and state laws and regulations.

Physician Name: _____

Physician Signature: _____

Date: _____

PHYSICIAN'S SIGNATURE

Signature: _____

PATIENT'S SIGNATURE

Signature: _____