

**REFLECTION MEDICAL, INC.**  
**3200 W. TEMPERANCE ROAD, TEMPERANCE, MI 48182**  
**TOLL FREE (866) 850-0777      FAX (734) 850-0606**

**SEATING/WHEELED MOBILITY LETTER OF MEDICAL NECESSITY  
FOR POWER WHEELCHAIRS (with a custom seating system)**

THIS FORM MUST BE SIGNED BY A PHYSICIAN AND SUBMITTED WITH THE PRIOR AUTHORIZATION REQUEST FOR POWER AND SPECIALLY CONSTRUCTED WHEELCHAIRS AND WHEELCHAIRS WITH CUSTOM SEATING SYSTEMS.

**GENERAL INFORMATION**

NAME:	BIRTH DATE:	MEDICAID BILLING #:	
RESIDENCE/FACILITY:		WEIGHT:	HEIGHT:
OTHER INS:	Est. Length of Need (# of Months/Yrs.)	Date of Onset/Injury:	
Diagnosis(es) and ICD-9 codes:			
Presenting Problem:			
Prognosis:			
Three most important facts a reviewer should know:			
a.			
b.			
c.			
Ambulation/Functional Walking Status:			
Bed Confined:                      Hours per day		Chair Confined:                      Hours per day	
Present Equipment Make:	Model:	Age of Equipment:	
Equipment Being Requested:			
Functional Consideration for lightweight or heavy duty wheelchairs (other than standard weight):			

**CLINICAL ASSESSMENT: Complete for Power wheelchairs and wheelchairs with any type of seating system.**

Indicate the body points of control affected.

Head                      Shoulders                      Trunk                      Hips                      Knees                      Feet

List any other affected body parts:

Please describe the following in detail: (e.g., flexible, fixed, degrees)

Sitting Posture/Balance:

Severity of Pelvic Tilt/Oblliquity/Rotation:

Leg / Feet Position:

Lordosis/Kyphosis/Scoliosis:

Head Position:

Shoulder/Scapula Position:

Cardio/ Respiratory Status:

Orthopedic Considerations:

Functional Status

ROM Limitations:

Muscle Strength Limitations:

Upper Extremity Function:

Lower Extremity Function:

Tone/ Movement/ Strength:

Does the consumer have moderate strength and/or moderate or severe tone (hyper or hypo) that prevents him/her from obtaining or maintaining symmetrical postures?    Yes    No

If yes, describe:

Explain why other standard components do not adequately meet the consumer's needs:

Therapeutic Objectives/Benefits of Prescribed Equipment:

Skin Condition/Integrity

Susceptible to Decubitus Ulcers?    Yes (If yes, explain below)    No

Sensation:

Present/History of Ulcers:

Location:

Stage:

Ability to Perform Pressure Relief:

Bowel/Bladder Status:

Other Special Considerations:

**CLINICAL ASSESSMENT FOR A POWER WHEELCHAIR ONLY(Continued)**

Is the consumer totally non-ambulatory & have severe weakness of the upper and lower extremities due to an orthopedic, neurological or muscular condition?    Yes    No  
 If yes, describe:

Does the consumer have any physical ability to operate a manual wheelchair?    Yes    No  
 If yes, explain why a power wheelchair is needed:

Does the consumer have the physical and mental ability to safely operate a power wheelchair?    Yes    No  
 If yes, describe:

Is the consumer dependent upon a power wheelchair for functional activities or is there a significant delay in the acquisition of independence in functional activities that can be positively impacted by a power wheelchair?    Yes    No  
 If yes, describe:

Document your assessment of the consumer's ability to operate a power wheelchair addressing the items below: CIRCLE ONE

Head Control/Head Position:	Good	Fair	Poor
Upper Extremity Functioning:	Good	Fair	Poor
Joystick Control Steering:	Good	Fair	Poor
Directionality-Steering Skill:	Good	Fair	Poor
Visual/Spatial Perception:	Good	Fair	Poor
Safety:	Good	Fair	Poor
Mobility Skills in Operation:	Good	Fair	Poor
Cognitive Level:	Good	Fair	Poor

Describe the functional status and explain how the power wheelchair will allow the consumer to be independent in mobility and allow the consumer substantial independence:

Bathing:

Grooming:

Toileting/Toilet Hygiene:

Telephone Use:

Transfers:

Use and Care of Equipment:

Activities for which the power wheelchair facilitates independent functioning while in school or work:

Other special considerations:

<b>EQUIPMENT PRESCRIPTION:</b>	
MOBILITY BASE AND ACCESSORIES (List all necessary equipment)	
a)	g)
b)	h)
c)	i)
d)	j)
e)	k)
f)	l)
DESCRIBE CUSTOM SEATING SYSTEM AND ANY NECESSARY MODIFICATIONS	
Seat:	
Back:	
ANY OTHER COMPONENTS	
1)	4)
2)	5)
3)	6)
DESCRIBE FEATURES TO ACCOMMODATE GROWTH (Can this wheelchair be enlarged or reduced in size?)	

<b>VENDOR INFORMATION</b>	
MANUFACTURER MAKE & MODEL :	
EQUIPMENT SUPPLIER SIGNATURE:	SIGNATURE DATE:
REFLECTION MEDICAL, INC 3200 W. TEMPERANCE RD., SUITE B, TEMPERANCE, MI 48182 (734) 850-0777	
THERAPIST'S SIGNATURE:	SIGNATURE DATE:
THERAPIST'S NAME:	LICENSE #:

**I have reviewed the certificate of medical necessity in its entirety and agree that it is any accurate assessment of the client & his/her needs.**

PHYSICIAN'S SIGNATURE:	DATE:
PHYSICIAN'S NAME	MEDICAID PROVIDER #: