

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 CUSTOM 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 Admission/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/Obliquity/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 won't 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 (Continued)

EQUIPMENT PRESCRIPTION:

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?)

VENDOR INFORMATION

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 #: