Minnesota Health Care Programs (MHCP)

Mobility Device Authorization Form

ASSIGNED NUMBER FROM MN–ITS

Use this form in addition to the MN–ITS Authorization Request transaction or the Authorization Form (DHS-4695) to request authorization for a mobility device. Fax this form with any additional or required documentation to the medical review agent.

If more space is needed, continue answer on a separate sheet and indicate the question you are answering. If coverage policy requires a PT/OT exam, attach documentation of that exam to this form.

Provider Information

PROVIDER NAME	NPI/UMPI
CONTACT NAME	PHONE NUMBER ( )

Recipient Information

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	MHCP ID NUMBER

DIAGNOSIS CODE		DESCRIPTION
HEIGHT	WEIGHT	OTHER RELEVANT INFORMATION ABOUT SIZE/STATURE

DESCRIBE RECIPIENT'S COGNITIVE AND COMMUNICATION IMPAIRMENT

LIVING ARRANGEMENT

☐ Home alone ☐ Home w/caregiver (who is caregiver ______________________________)

☐ Nursing home ☐ Group home ☐ Assisted Living ☐ ICF/DD

ADL ASSISTANCE

☐ Totally dependant ☐ Partially dependant ☐ Independent

IF RECIPIENT REQUIRES ASSISTANCE FOR ACTIVITIES OF DAILY LIVING, LIST AND DESCRIBE THEIR ABILITY

RECIPIENT HAS PCA SERVICES	HOURS PER DAY	HOURS PER DAY RECIPIENT IS ALONE
☐ Yes ☐ No		

DESCRIBE PCA RESPONSIBILITIES

IF RECIPIENT IS IN A HOSPITAL, NURSING FACILITY, OR BOARD AND CARE, LIST SPECIFIC DISCHARGE PLAN OR DESCRIPTION OF UNUSUAL MEDICAL NEED

MOBILITY DEVICE REQUESTED ☐ Power ☐ Manual	MAKE	MODEL

Describe recipient's medical condition and medical necessity for the requested equipment. Explain the mobility related activities of daily living the recipient is unable to perform and how the mobility device will allow the recipient to perform those ADLS. Include any complicating previous or present physical conditions (e.g., skin breakdown, pain, contractures).

Scooter required. Explain the reason a manual wheelchair would not meet the recipient's needs (e.g., exertion scale rating, distances recipient can self propel); how far the recipient can independently ambulate; if the recipient can safely operate the scooter; if the recipient can safely transfer in and out; if the recipient has adequate trunk stability to ride safely in the scooter; how the recipient will transport the scooter.

POWER WHEELCHAIR REQUIRED. EXPLAIN THE REASON A SCOOTER WOULD NOT MEET THE RECIPIENT'S NEEDS

Explain where the wheelchair/scooter will be used; the approximate duration at each location (hrs/day and days/week); the types of surfaces on which the chair will be used.

RECIPIENT'S ROLES AND RESPONSIBILITIES IN THE COMMUNITY, AT WORK AND AT HOME

Explain how the recipient has adequate judgment, maturity and skill to safely operate this wheelchair/scooter in all environments, including crowded situations.

Trials of requested equipment in the recipient's home, school, work, and community environments, etc., to assure it will meet the recipient's needs, and fit in all areas of the recipient's home. Document the outcome of the trial, including an assessment of the accessibility of the home and all other necessary environments.

Ramp exists ☐ Yes ☐ No   Stairs exist ☐ Yes ☐ No   An elevator exists ☐ Yes ☐ No

If provider does not have a wheelchair for recipient trial, DHS does pay for rental up to 3 months, without an authorization. Rental will be deducted from the purchase price, unless extenuating circumstances are proven.

EXPLAIN HOW THE EQUIPMENT WILL BE TRANSPORTED

The equipment was transported during the trial period. ☐ Yes ☐ No

The equipment folds or disassembles easily for transport. ☐ Yes ☐ No

The equipment fits into the family vehicle. ☐ Yes ☐ No

List all less costly alternatives and explain the reason that equipment will not meet the recipient's medical needs. Provide cost comparison of comparable mobility devices and thoroughly document the reasons less costly alternatives do not meet the recipient's needs.

If requesting a group 4 power wheelchair, explain the reason a group 3 PWC does not meet the recipient's needs. If requesting a group 3 power wheelchair, explain the reason a group 2 PWC does not meet the recipient's needs.

The recipient requires (check all that apply, explain medical necessity and least costly alternative for each)

☐ Power elevating leg rests	
☐ Reclining back feature	
☐ Tilt option	
☐ Non-standard seat width	
☐ Non-standard seat depth	
☐ Power seat elevator	
☐ Attendant Control	

List all other requested accessories that require authorization or pricing and the medical necessity of each.	
Description	**Medical Necessity**

List the recipient's current mobility equipment, age of equipment, make, and model. Describe the reason this chair is no longer meeting the recipient's medical needs. **If current chair is being replaced due to extensive repairs, give estimates on repairs needed.**	
APPROXIMATE LENGTH OF TIME NEEDED (purchase or rental)	(If the need for a wheelchair is permanent, wheelchair rental is not appropriate. Request authorization for purchase).

Attach manufacturer's quote, price list or invoice to the request for authorization for manual pricing. Do not modify, alter or change the pricing documentation. Do not block out any information on the pricing documentation.

SIGNATURE OF EQUIPMENT SPECIALIST	DATE
SIGNATURE OF PT/OT/OTHER PROFESSIONAL INVOLVED IN EVALUATION AND CREDENTIALS	DATE
SIGNATURE OF PHYSICIAN VERIFYING INFORMATION	DATE