MEDICAID WHEELCHAIR FORM
Part 2 of 2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Patient Name:_____ **DOB:**_____

CVA or Injury Status	Is this wheelchair necessary due to a CVA or injury? ☐YES ☐ NO If yes, what was the date of the CVA or injury? _____/_____/_____ Area affected by the CVA or injury include: _____ Describe the injury if applicable: _____ Describe limitations: _____
Prognosis	What is the member's potential for rehabilitation? ☐ GOOD ☐ FAIR ☐ POOR What is the member's prognosis? ☐ GOOD ☐ FAIR ☐ POOR
Activities of Daily Living	What are the member's activities of daily living that require the use of a wheelchair?
Wheelchair Specs	List the wheelchair specifications that are necessary and the justification for medical necessity (elevating footrests, detachable arms, extra-wide, light-weight, etc.) If and extra-wide wheelchair is prescribed, will the member's home (halls and doorways) accommodate the larger size wheelchair? ☐ YES ☐ NO

Ordering Physician

I certify that the manual wheelchair listed on this certificate is medically necessary for this member, and that I have had a face-to-face evaluation with this member to discuss and review the appropriateness of the device within the six (6) months preceding this order, and I am enrolled with Georgia Medicaid for the purpose of ordering, referring, or prescribing medical services.

Date of face-to-face evaluation _____/_____/_____ (Must have occurred within 180 days prior to the order date)

Physician's Signature _____ Date_____/_____/_____

Stamps are not an acceptable form of authentication for the date or signature on a certificate of medical necessity or prescription/written order submitted to Georgia Medicaid.