MEDICAID WHEELCHAIR FORM
Part 1 of 2

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

CERTIFICATION OF MEDICAL NECESSITY MANUAL WHEELCHAIR
PT/OT EVALUATION REQUIRED FOR MEMBERS UNDER 21

PT/OT evaluation requirement excludes members under twenty-one (21) years of age requesting a short-term rental.

Certification Type/Date: INITIAL ____/____/____ REVISED ____/____/____	
Members Name:	**Members Medicaid Number (Do Not List Mother's ID):**
Patient DOB ____/____/____ Sex _____ HT. _____(in) WT. _____(lbs.)	
Suppliers Name: Professional Medical HHC **Suppliers NPI Number:** 1942287131	**Suppliers Address and Telephone Number:** 4855 Memorial Drive Stone Mountain, GA 30083 404-292-9190
Physicians Name: **Physicians NPI Number:**	**Physicians Address and Telephone Number:**
HCPCS Code(s)	
Place of Service	

Primary Diagnosis:_____ICD-10 Diagnosis Code_____

Secondary Diagnoses supporting medical necessity:_____

ICD-10 Diagnosis Code(s)_____ Length of Need_____

PHYSICAL EXAMINATION:

Provide detailed results of the physical examination as it relates to the member's mobility needs, and any related needs for special accommodations, options or accessories.

Ambulatory Status	Is the member ambulatory? ☐ YES ☐ NO If yes, describe in detail:
Amputation Status	Is the wheelchair necessary due to surgery or amputation? ☐ YES ☐ NO If yes, list the type of surgery and the date it was performed: _____ Date_____ Expected prognosis: _____