New Mexico Medicaid Utilization Review
P.O. Box 27950 Albuquerque, NM 87125-7950

Medical Justification for Power Wheelchair

(applicable codes K0010, K0011, K0012, K0013, and K0014)

Date: ______________________________

Recipient: ____

Medicaid #: ____

Circle One

1. Does the patient currently own or rent a wheelchair? Y N
2. If the patient owns a wheelchair, when was it purchased (age), and what is its condition?
   ____
   ____
3. Could the current wheelchair be modified to meet the recipient's needs? Y N
4. Does the patient have a medical condition such that without the use of a wheelchair, he/she would otherwise be bed or chair confined? If yes, please provide the diagnosis. Y N
   ____
5. For what clinical reason is the patient unable to use a manual standard or a lightweight wheelchair? ____
   ____
   ____
6. Can the recipient safely transfer in and out of the wheelchair or does the recipient have adequate trunk stability to safely ride in motorized wheelchair? Y N
7. Is the recipient able to safely operate the controls on a power wheelchair? Y N
8. Is the need for a power wheelchair long term? Y N

Please provide documentation related to the patient's diagnosis, functional status, duration of condition, prognosis, past experience with wheelchair, routine activities, and level of independence with use of a wheelchair. Please provide a clear description of what is customized.

M.D. Signature: ____