BlueCross BlueShield of New Mexico

Wheelchair Medical Necessity and Home Evaluation Verification Form

Type of request

Select one	☐ Repair	☐ Replacement	☐ Initial
Select one	☐ Standard	☐ Urgent	

A repair or replacement request is considered urgent if the current wheelchair is inoperable or unsafe to operate. Requests that do not meet these criteria will be reclassified from urgent to standard priority. You will receive written notification once a determination has been made.

Is the wheelchair currently inoperable or intermittently inoperable? ☐ Yes ☐ No

Is the wheelchair currently unsafe to operate? ☐ Yes ☐ No

Does the wheelchair supplier, provider or member have access to a loaner or suitable alternative device? ☐ Yes ☐ No

Provider information

Name of provider conducting evaluation	
Contact person	
Phone	Fax
Address	

Subscriber information

Subscriber name	Relationship to member	
ID number	Group number	
Address		
City	State	ZIP

Member information

Member name		Date of birth	
Address (if different from subscriber)			
City		State	ZIP
Height	Weight	Gender	Referral number (if applicable)
Primary diagnosis		Date	Duration
Secondary diagnosis		Date	Duration
ICD-10 codes			
Current Procedural Terminology (CPT®) codes			
Healthcare Common Procedure Coding System codes			

Medical and home evaluation (Questionnaire for providers)

Section A – Repair requests

1. Was a service evaluation completed? ☐ Yes ☐ No (Please submit report for review)
2. When did the member originally receive the wheelchair?
3. Is the wheelchair currently under warranty? ☐ Yes ☐ No
4. Is the cost of repair more than cost of replacement? ☐ Yes ☐ No

Section B – Replacement requests

1. When did the member originally receive the wheelchair?
2. Why is the replacement needed? (e.g., normal wear and tear, natural disaster, etc.)

3. Can the item be repaired? ☐ Yes ☐ No
4. Did the ordering physician document a change in the member's condition and/or the rationale for the replacement wheelchair? ☐ Yes ☐ No

Section C – Initial and replacement requests

1. Date you examined the member?
   Date you attested to the letter of medical necessity (optional)?
2. What has changed in the member's medical condition that now impairs the member's mobility?
3. Until now, what has been the member's mode of mobility in the home?
4. Is the member able to safely operate a manual wheelchair? ☐ Yes ☐ No If no, why?
5. Is the member able to safely operate and control a power-operated vehicle? ☐ Yes ☐ No
6. Location where MWC or POV will primarily be used?
7. Is the member's duration of need greater than six months? ☐ Yes ☐ No
8. Can the member safely transfer in and out of a POV? ☐ Yes ☐ No
9. Does the member have adequate trunk control to safely ride in a POV? ☐ Yes ☐ No
10. List activities for which equipment will primarily be used?
11. What wheelchair accessories do you anticipate the member needing, and why?
12. Will the MWC or POV fit through the doorways into and inside of the home? ☐ Yes ☐ No
13. Does the physical layout of the home allow unhindered use of the MWC or POV? ☐ Yes ☐ No
14. Are there any surfaces or obstacles inside the home that may render the MWC or POV unusable in the home? ☐ Yes ☐ No
15. The member's home should provide adequate access, maneuvering space and surfaces, as well as prevailing temperature and physical layout, for the safe operation of the MWC or POV. Overall, is the home environment conducive both to getting the MWC or POV into the home and safely operating within the home? ☐ Yes ☐ No
16. Are the member's physical and mental capabilities adequate and appropriate for the device requested? ☐ Yes ☐ No
17. Is the member motivated and willing to use the device routinely? ☐ Yes ☐ No

Provider attestation and signature

The provider attests that the member and the home have been evaluated, that the equipment requested is medically necessary and appropriate for the member, that the home environment is conducive to the safe and successful operation of the device, and that this questionnaire has been answered honestly and accurately.

Provider's name _____

Provider's signature _____Date _____

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