

**Indiana Health Coverage Programs  
Medical Clearance for Motorized Wheelchair Purchase**

<b>Member Name:</b> _____	<b>RID#</b> _____
<b>Primary and Secondary Diagnoses:</b> _____	<b>Length of illness:</b> _____
<b>Height:</b> _____	<b>Weight:</b> _____

*405 IAC 5-19-9 (a) – Medicaid reimbursement is available for wheelchairs or similar motorized vehicles, subject to the restrictions in this section, and requires prior authorization.*

*Motorized vehicles are covered only when the member is enrolled in a school, sheltered workshop, or work setting, or if the member is left alone for significant periods of time. It must be documented that the member can safely operate the vehicle and that the member does not have the upper extremity function necessary to operate a manual wheelchair.*

*(c) Requests for wheelchairs or similar motorized wheelchairs require a completed medical clearance form submitted with the prior authorization request before the request shall be reviewed.*

**NOTE: Requests for motorized/power wheelchairs must be provided and signed by a Physical Medicine and Rehabilitation Practitioner (Physiatrist) in order to be considered for approval.**

1.	Does the member currently have a wheelchair? _____	What brand and model? _____
2.	What is the condition of the current chair? _____	
3.	Why is this chair no longer effective for this member? Explain _____ _____	
4.	Can it be repaired? _____	Estimated cost? _____
		Will this chair be a second chair for this person? _____

**Functional Status**

Please provide the functional status of the member that warrants the use of the wheelchair and accessories.

1.	Upper extremities (be specific)	_____
2.	Lower extremities (be specific)	_____
3.	Hand function (be specific)	_____
4.	Contractures (be specific)	_____
5.	Neck/spine (be specific)	_____
6.	Static/dynamic sitting balance (be specific)	_____
7.	Ambulation (be specific)	_____
8.	Transfer/bed mobility (be specific)	_____
9.	ADLS (be specific)	_____
10.	Medical problems that require special positioning equipment (be specific)	_____
11.	Other	_____

The provider may submit an Occupational Therapy or Physical Therapy evaluation if the above information is not sufficient for review.

**Residence**

Where does the member reside?       Home       Group Home       Nursing Facility       ICF/MR

**Motorized Wheelchair Criteria**

1.	Does the member live alone or have caregivers? If the member has a caregiver/family, how long is the member left alone? Explain _____
	_____

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2. Does the member have a caregiver in the home who is physically capable of assisting the member? Explain.

3. Is the member employed or attending a vocational or sheltered workshop? If so, where? \_\_\_\_\_

4. Does the member attend school? If so, where? \_\_\_\_\_

5. How does the member get to and from work, workshop, or school? \_\_\_\_\_

6. Can the member operate a manual wheelchair? If so, how far? \_\_\_\_\_

7. Does the member have the upper extremity function necessary to operate a motorized wheelchair? Explain. \_\_\_\_\_

8. Can the member safely operate the motorized wheelchair? Explain? \_\_\_\_\_

**Wheelchair Specifications**

1. Specify the Brand and Model of the requested wheelchair. \_\_\_\_\_

2. What are the special features of the above-mentioned wheelchair that are needed by the member? \_\_\_\_\_

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**Special Feature**

**Body Measurements**

- |                |              |       |
|----------------|--------------|-------|
| a. Hemi height | Knee to heel | _____ |
| b. Seat depth  | Femur length | _____ |
| c. Seat width  | Hip width    | _____ |
| d. Other       |              | _____ |

**Wheelchair Accessories**

List the accessories needed to make this wheelchair functional for the member and the corresponding problem that will be corrected or will be prevented from worsening. Use an additional page if more items need to be listed.

**Accessory**

**Member Specific Problem Corrected**

Accessory	Member Specific Problem Corrected

**Comments:**

\_\_\_\_\_

\_\_\_\_\_

**Signature of requesting physician** \_\_\_\_\_

**Date** \_\_\_\_\_

*Requires approval and signature by a Physical Medicine and Rehabilitation Practitioner (Physiatrist)*