BlueCross BlueShield of Illinois

Wheelchair Medical Necessity and Home Evaluation Verification Form

Blue Cross and Blue Shield of Illinois (BCBSIL) reviews repair, replacement and initial (first time) requests for manual wheelchairs (MWCs) and power-operated vehicles (POVs) (i.e., Power Wheelchair, Scooter, Other POV) as required according to details of our members' benefit plans and medical necessity criteria outlined in **BCBSIL's Medical Policies**. As noted in **BCBSIL Medical Policy DME101.010, Wheelchairs and Accessories**, this form, or any reasonable substitute with the same wheelchair medical necessity/home evaluation information, should be used for repair, replacement and initial review requests for commercial non-HMO BCBSIL members. (Note: To electronically submit predetermination requests and supporting documentation for our commercial non-HMO members, you can use the **Availity® Attachments tool**.)

Instructions

1. **Complete all fields and answer all questions fully.**
2. **Complete all appropriate Section(s) (i.e., repair, replacement, initial).** *For all replacement requests, you must complete Sections B and C.*
3. **Gather all necessary medical record documentation, as appropriate, to support your request.**
   Here are some examples that may apply:
   - Seating evaluation
   - Service evaluation
   - Equipment recommendation(s) with physician justification(s) (*e.g., Power wheelchair needed because the patient cannot self-propel a manual wheelchair.*)
   - Physician prescription
4. **Submit your completed form and supporting medical record documentation to BCBSIL.**
   Follow your current process for submission of this type of information.

Note: Failure to include necessary medical record documentation may result in delays or hinder the ability to confirm medical necessity of your request.

Type of Request

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

Note: 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 re-classified 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 Number:	Fax Number:
Address (Street Address, City, State, Zip):	

Subscriber Information

Subscriber Name:	Relationship to Patient:	
Identification Number:	Group Number:	
Street Address:		
City:	State:	Zip:

Patient Information

Patient Name:		Date of Birth:	
Street 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 Code(s):			
Current Procedural Terminology (CPT®) Code(s):			
Healthcare Common Procedure Coding System (HCPCS) Code(s):			

Medical and Home Evaluation (Provider Questionnaire)

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? (*i.e., 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 your patient:
   Date you attested to the letter of medical necessity (*optional*):
2. What has changed in your patient's medical condition that now impairs the patient's mobility?

3. Until now, what has been your patient's mode of mobility in the home?

4. Is your patient able to safely operate an MWC? ☐ Yes ☐ No If no, why not?

5. Is your patient able to safely operate and control a POV? ☐ Yes ☐ No
6. Location where MWC or POV will primarily be used:
7. Is your patient's duration of need greater than 6 months? ☐ Yes ☐ No
8. Can your patient safely transfer in and out of a POV? ☐ Yes ☐ No
9. Does your patient have adequate trunk control to safely ride in a POV? ☐ Yes ☐ No
10. List activities for which equipment is primarily to be used:

11. What wheelchair accessories do you anticipate your patient 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. Your patient'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 to safe operation within the home?
    ☐ Yes ☐ No
16. Are your patient's physical and mental capabilities adequate and appropriate for the device requested?
    ☐ Yes ☐ No
17. Is your patient motivated and willing to use the device routinely ☐ Yes ☐ No

Provider Attestation and Signature

The provider attests that the patient and the home have been evaluated, that the equipment requested is medically necessary and appropriate for the patient, that the home environment is conductive 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: _____