Power Mobility Device Questionnaire Form

Submit completed form via fax to 1-833-263-4869 or email PriorAuth@MediGold.com.

General Information

Today's Date: ______________________

Member's Name

Member's ID Number

Member's Address

Member's Phone Number

Gender

Date of Birth

Provider's Name

Provider's Phone Number

Provider's TIN Number

Provider's NPI Number

Diagnosis

Equipment

☐ Electric Wheelchair ☐ Motorized Scooter

Has the patient had a face to face examination in the last 45 days?

☐ Yes ☐ No

Does the patient have mobility related ADLs that cannot effectively be performed in the home using a cane, walker or manually operated wheelchair?

☐ Yes ☐ No

Does the patient have a personal mobility deficit sufficient to impair the performance of mobility related ADLs such as toileting, feeding, dressing, grooming and bathing in customery locations in the home?

☐ Yes ☐ No

Does the home have adequate modifications for usage?

☐ Yes ☐ No

Is the length of time needed greater than 90 days?

☐ Yes ☐ No

Need for further customization:

Does the patient have quadriplegia, a fixed hip angle, a trunk cast or brace, excessive extensor tone of the trunk muscles, or a need to rest in a recumbent position two or more times during the day?

☐ Yes ☐ No

Does the patient have a need for arm height different than available using non-adjustable arms?

☐ Yes ☐ No

Additional comments:

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Member's Name	**Member's ID**

Physician's Signature

Denied	**Approved**
☐	☐
Vendor	**Equipment** ☐ Electric Wheelchair ☐ Motorized Scooter
Authorization Number	**Date Span**

IN ADDITION TO COMPLETING THIS FORM, PRIOR AUTHORIZATION MUST ALSO BE OBTAINED

Member must be notified of appropriate coinsurance

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