



26834 Lawrence  
Center Line, MI 48047  
1-888-246-7667

Please Fax Completed Form To: 1-800-882-7071

## Wheelchairs & Accessories - Written Order

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ Account Number \_\_\_\_\_  
 Order Date \_\_\_\_\_ Length of Need, 99 (lifetime) or \_\_\_\_\_ months Height \_\_\_\_\_ Weight \_\_\_\_\_  
 Diagnosis \_\_\_\_\_

### Wheelchairs

- ☐ Standard Manual Wheelchair with Anti-Tipping Device, Footrests, Heel Loops, Seatbelt, Wheel Lock Extensions, Back Cushion, and Seat Cushion
- ☐ Heavy Duty Wheelchair (251 Lbs. +) with Anti-Tipping Device, Footrests, Heel Loops, Seatbelt, Wheel Lock Extensions, Back Cushion, and Seat Cushion
- ☐ Transport Chair
- ☐ Heavy-Duty Transport Chair (301 lbs. +)

Optional (if known): Seat width \_\_\_\_\_ Seat Depth \_\_\_\_\_

### Accessories

- ☐ Elevating Leg Rests
- ☐ Residual Limb Support Left / Right
- ☐ Oxygen Holder
- ☐ One Arm Drive Left / Right
- ☐ Transfer Board
- ☐ Reclining Back w/ Headrest

### Cushions

- ☐ General Use Foam Seat Cushion
- ☐ General Use Foam Back Cushion
- ☐ Skin Protection Seat Cushion *(Patient has decubitus ulcers or history of decubitus ulcers on the lower back/sacrum, hip and/or buttock area)*

**\*\*Required For MICHIGAN Medicaid Patients Only \*\***

**Reason for Medical Necessity (other than diagnosis)** \_\_\_\_\_

Prescribers Printed Name & Credentials \_\_\_\_\_ NPI \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

### Medical records must state the medical necessity for each item ordered

#### **Standard Manual Wheelchair**

The patient has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADLs); **AND**

- The mobility limitation cannot be sufficiently resolved using an appropriately fitted cane or walker; **AND**
- Use of a manual wheelchair will significantly improve the patient's ability to participate in MRADLs regularly in the home; **AND**
- The patient has not expressed an unwillingness to use the manual wheelchair that is provided in the home; **AND**
- The patient has sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the manual wheelchair provided in the home during a typical day OR has a caregiver who is available, willing, and able to aid with the wheelchair.

#### **Heavy Duty Wheelchairs**

The medical record supports that the patient weighs more than 250 pounds.

#### **Transport Chairs**

Covered as an alternative to a standard manual wheelchair if all basic coverage criteria are met **AND**

Must include a description of why the patient cannot use a standard manual wheelchair on their own. Documentation provides specific information that the patient has a caregiver who is available, willing, and able to aid with the transport chair.



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