

**FOR A POWER OPERATED VEHICLE (POV) AKA SCOOTER, STANDARD OR BARIATRIC***The DME provider must complete all applicable areas not completed by the clinician or therapist.*

Dear Clinician/DME Provider: Cooperation in completing this form will ensure that the beneficiary receives full Medi-Cal consideration regarding the request for a scooter. Medi-Cal reimbursement is based on the least expensive medically appropriate equipment that meets the patient's medical need.

*Incomplete information will result in a deferral, denial or delay in payment of the claim.*

**REQUIRES THE ATTENDING CLINICIAN TO COMPLETE AND SIGN****SECTION 1—Clinician's Information:**

Clinician Name (Print)		Last	First	Phone Number ( )	License Number
Address	Street	City		State	ZIP

Clinician's description of the patient's current functional status and need for the requested equipment: \_\_\_\_\_

**SECTION 2—Patient's Information: New Rx (For Rx Renewal, please also complete 2A below)**

Patient Name (Print)		Last	First	Phone Number ( )	Date of Birth mm / dd / yy	Medi-Cal Number
Address	Street	City		State	ZIP	

Date of last face-to-face visit with the beneficiary: \_\_\_\_\_

Is this beneficiary expected to be institutionalized within the next 10 months? Yes  No

Explain "Yes" Answer: \_\_\_\_\_

Equipment required for:

- Less than 10 months (code the TAR for a rental)  
 More than 10 months (code the TAR for a purchase)

**SECTION 2A—For Renewal**

Verification of continued medical necessity and continued usage by the beneficiary must be done at each TAR renewal.

**SECTION 3—POV Requested:**

a) Standard HCPCS Code(s):	b) Custom/Bariatric HCPCS Code(s):
c) Replacing existing equipment? <input type="checkbox"/> Yes <input type="checkbox"/> No Model/Serial #:	Explain "Yes" Answer: Date of purchase:
d) Attach repair estimate if replacement with similar equipment is requested.	
e) Other DME the beneficiary currently has:	f) Current wheelchair:
g) How many hours per day of usage:	h) Accessories requested and why (use attachments):
i) Custom features requested and why (use attachments):	
j) Is this beneficiary able to safely operate the requested equipment? <input type="checkbox"/> Yes <input type="checkbox"/> No	

**SECTION 4—Diagnosis Information:**

Diagnoses: \_\_\_\_\_

Date of onset: \_\_\_\_\_

**SECTION 5—Pertinent History:**

History of pressure sores: \_\_\_\_\_

None at Present:  Yes  No

Beneficiary has a history of pressure sores:  Yes  No

Beneficiary lacks protective sensation and is at risk for developing sores:  Yes  No

Beneficiary's protective sensation is intact:  Yes  No

If sores are present, location and stage: \_\_\_\_\_

**SECTION 6—Pertinent Exam Findings:**

Upper Extremity:	Weakness <input type="checkbox"/>	Paralysis <input type="checkbox"/>	Contractures <input type="checkbox"/>
Comments:	_____		
Lower Extremity:	Weakness <input type="checkbox"/>	Paralysis <input type="checkbox"/>	Contractures <input type="checkbox"/>
	Amputee <input type="checkbox"/>	Level: Left <input type="checkbox"/> Right <input type="checkbox"/>	Edema <input type="checkbox"/>
Comments:	Cast <input type="checkbox"/>	Ataxia <input type="checkbox"/>	HT: _____ WT: _____

Sitting posture/Deformity: \_\_\_\_\_

Cognitive status: \_\_\_\_\_

Requires wheelchair supervision:  Yes  No

Vision: Impaired  Normal

**SECTION 7—Living Environment:**

House/condominium  Apartment  Stairs  Elevator  Ramp  Hills  SNF  ICF/DD  B&C

Doorway widths and home layout for adequate wheelchair use indoors verified except:

Bathroom  Bedroom  Kitchen  Other: \_\_\_\_\_

Living Assistance: Lives Alone  With Other Person(s)  Alone Most of the Day  Alone at Night

Attendant Care:  Live in attendant or \_\_\_\_\_ Hours/day  Homemaker Hours \_\_\_\_\_

Transportation:

To/from medical appointments?  Yes  No Local Community?  Yes  No Beneficiary drives from the wheelchair?  Yes  No

Tie-down system: \_\_\_\_\_

Public Transportation: \_\_\_\_\_

**SECTION 8—Transportation:**

To/from medical appointments?  Yes  No Local Community?  Yes  No

**SECTION 9A—Activity Level:**

Number of hours per day using the POV: \_\_\_\_\_ Distances the beneficiary pushes/drives daily: \_\_\_\_\_

Beneficiary will use the POV: At home  Outside  For physician visits  Job related activities  School

Social Activities  SNF  ICD/DD

Beneficiary is unable to effectively propel any manual wheelchair: At Home  In the community

**SECTION 9B—Ambulation:**

Beneficiary is independently ambulatory:  Yes  No Beneficiary is unable to walk:  Yes  No

Beneficiary ambulation is limited by: \_\_\_\_\_

Beneficiary's ambulation ability is expected to change:  Yes  No

Beneficiary is scheduled for additional lower extremity medical/surgical intervention(s).  Yes  No

**SECTION 10—Narrative description of the POV and cost and justification for higher cost:**

This beneficiary was evaluated for a Manufacturer/Model(s): \_\_\_\_\_ and was unable to use it in home and/or community for mobility.

Other justifications for this requested "high-end" POV: \_\_\_\_\_

Manufacturer: \_\_\_\_\_ Model: \_\_\_\_\_ Provider Name: \_\_\_\_\_



Provider Location: \_\_\_\_\_

**SECTION 11—DME provider/Therapist attestation and signature/date:**

*By my signature below, I certify to the best of my knowledge that the information contained in this Certificate of Medical Necessity is true, accurate and complete and I understand that any falsification, omission or concealment may subject me to criminal liability under the laws of the State of California.*

Name of therapist answering these sections, if other than prescribing clinician or DME provider (please print): \_\_\_\_\_


Name: \_\_\_\_\_ (Please print) Title: \_\_\_\_\_ (OT, PT, RESNA, etc.) DME Provider Name: \_\_\_\_\_ (Please print)

 \_\_\_\_\_ (Use Ink - A signature stamp is not acceptable) Date: \_\_\_\_\_  \_\_\_\_\_ (Use Ink - A signature stamp is not acceptable)

**SECTION 12—Clinician attestation and signature/date:**

*I certify that I am the clinician identified in this document. I have reviewed this Certificate of Medical Necessity and I certify to the best of my knowledge that the medical information is true, accurate, current and complete, and I understand that any falsification, omission, or concealment may subject me to criminal liability under the laws of the State of California.*

Clinician's Signature: \_\_\_\_\_

 \_\_\_\_\_ (Use Ink - A signature stamp is not acceptable) Date: \_\_\_\_\_