

360 DEGREE
Patient Care

provided by:

Jayhawk pharmacy
& patient supply



Jayhawk Patient
Supply
2620 SW 6th Ave.
Ste "E"
Topeka, KS 66606
785-235-9700
785-235-9703 Fax

Jayhawk Pharmacy &
Patient Supply
2860 SW Mission Woods
Drive
Topeka, KS 66614
785-228-9700
785-228-1375 Fax

Order for Manual Wheelchair (Standard/Lightweight/Heavy Duty)

Patient Name: _____ DOB: _____

Ordering Physician: _____

Height: _____ Weight: _____ Length of need _____ (99Lifetime)

ICD 10 Diagnosis code _____

Size w/c: _____ General use back: _____ Cushion: _____ Elevating Leg Rests _____

- 1) Does the patient have a mobility limitation that significantly impairs his/her ability to participate in one or more mobility related activities of daily living (MRADL'S) such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home?
_____ Yes _____ No Explain mobility limitation(s): _____
How far can the patient ambulate? (be quantitative) _____ feet

- 2) Can the patient's mobility limitation be sufficiently resolved by the use of an appropriately fitted cane, or walker?
_____ Yes _____ No
- 3) Does the patient home provide adequate access between rooms, maneuvering space, and surfaces for use of the manual wheelchair that is provided?
_____ Yes _____ No
- 4) Will the use of a manual wheelchair significantly improve the patient's ability to participate in MRADL's and the patient will use it on a regular basis within the home?
_____ Yes _____ No
- 5) Has the patient expressed willingness to use the manual wheelchair within the home?
_____ Yes _____ No
- 6) Is the patient able to adequately self-propel (without being pushed) in a standard (45lb) wheelchair?
_____ Yes _____ No
- 7) If NO, would the patient be able to adequately self-propel (without being pushed) in a lightweight (34lb) wheelchair?
_____ Yes _____ No
- 8) If ordering Leg Rests, does the patient have a cast, brace, or musculoskeletal condition, which prevents 90 degree flexion of the knee, or does the patient have significant edema of the lower extremities that require Elevating Leg Rests? _____ Yes _____ No
- 9) How many hours a day will the patient be in the manual wheelchair: _____
- 10) ***If the patient is not able to self-propel a standard wheelchair then you MUST document."Patient is able and will to self-propel a lightweight wheelchair but they were not able to self-propel a standard wheelchair in their home setting.***

*****All of the above must be documented in your office note or we will not be able to provide a wheelchair to your patient under insurance. *****

Ordering Provider signature: _____ Date _____

NPI: _____

We need Face Sheet with insurance , RX and office visit note covering all above items:



Jayhawk Pharmacy Services

Patient Supply
2620 SW 6th Ave.
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785-235-9700
785-235-9703 Fax
NPI: 1033397716

Pharmacy & Patient Supply
2860 SW Mission Woods Drive
Topeka, KS 66614
785-228-9700
785-228-1375 Fax
NPI: 1104852672

Custom Prescription Center
6730 SW 29th
Topeka, KS 66614
785-228-9740
800-338-9700

Medicare Requirements for a Manual Wheelchair

A manual wheelchair is covered if:

- a) Criteria A, B, C, D and E are met; and
- b) Criterion F or G is met

Additional Coverage criteria for specific devise are listed below.

- A. The beneficiary has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADLs), such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home.

A mobility limitation is one that:

1. Prevents the patient from accomplishing an MRADL entirely, or
2. Places the patient at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform and MRADL; or
3. Prevents the patient from completing an MRADL within a reasonable time frame.

- B. The beneficiary's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker.

- C. The beneficiary's home provides adequate access between rooms, maneuvering space, and surfaces for use of the manual wheelchair that is provided.

- D. Use of a manual wheelchair will significantly improve the beneficiary's ability to participate in MRADLs, and the patient will use it on a regular basis in the home.

- E. The patient has not expressed an unwillingness to use the manual wheelchair that is provided in the home.

- F. The patient has sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the manual wheelchair that is provided in the home during a typical day.

- Limitation of strength, endurance, range of motion, or coordination, presence of pain or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function.

- G. The Patient has a caregiver who is available, willing and able to provide assistance with the wheelchair.

- ❖ If the manual wheelchair is only for use outside the home, it will be denied as not reasonable and necessary.



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The office visit note must have this information documented in order for Medicare to pay for the wheelchair. If this is not documented, then Medicare will deny the claim for the wheelchair. This cannot be fill-in-the-blank; it must be documented by the Dr or APRN in the office visit note.

I saw ____ Patient name _____ today in regards to their need for a lightweight wheelchair due to _____. The wheelchair will allow them to complete their ADLS safely and timely. They are unable to use a cane or walker due to _____. They were willing and able to self propel in a lightweight wheelchair but they were not able to self propel in a standard wheelchair.