

CERTIFICATE OF MEDICAL NECESSITY**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 ☐ NoBeneficiary 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: _____