Meyer, Alisha M (MRN 02894295)

Authorized (No Approval Needed)

Referral

Referral # 4116358354

Referral Information

Referral #	Creation Date	Referral Status	Status Update
4116358354	01/13/2025	Authorized	01/13/2025: Status History

Status Reason	Referral Type	Referral Reasons	Referral Class
No Approval Needed	DME/P&O	Provide DME/appliance/Brace/supplies only	Outgoing

To Specialty	To Provider	To Location/Place of Service	To Department	To POS Type
Durable Medical Equipment	Inc, Bellevue Healthcare II	BELLEVUE HEALTHCARE - LIBERTY LAKE	none	Home

To Vendor	Referred By	By Location/Place of Service	By Department
none	Sikora, Michael J, MD	LIDGERWOOD HEALTH CARE CENTER	LWH FAMILY PRACTICE

Priority	Start Date	Expiration Date	Referral Entered By
Routine	01/13/2025	04/15/2025	Sikora, Michael J, MD

Visits Requested	Visits Authorized	Visits Completed	Visits Scheduled
1	1		

Procedure Information

Service Details

Procedure	Modifiers	Revenue Code	Provider	Requested	Approved
~~DME0081 - REF DME CANES~~	none	~~none~~	Healthcare, Apria	0	0
E0105 - CANE QUAD OR THREE PRONG	NU	none		1	1

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Diagnosis Information

Diagnosis
R29.898 (ICD-10-CM) - Right leg weakness

Referral Notes

Number of Notes: 6

Type	Date	User	Summary	Attachment
External OAL Notification	01/13/2025 12:51 PM	Deishl, Sonja	Auto: 31853-PROVIDER EXT REF LETTER - NO CARRIER AUTH	-

Note:

RS

KAISER PERMANENTE®
Kaiser Foundation Health Plan of Washington
LIDGERWOOD HEALTH CARE CENTER
6002 N Lidgerwood St
Spokane, WA 99208-1124

January 13, 2025

BELLEVUE HEALTHCARE II
2015 152nd Ave NE
Redmond WA 98052-5521

Dear BELLEVUE HEALTHCARE II:

Alisha M Meyer has been referred to you for a consultation. At the time of this referral, this patient coverage is No carrier known.. The office the patient is referred to will need to confirm coverage and eligibility.

Medical Record Number: <E02894295>
Date of Birth: 06/14/1984
Patient Diagnosis:

Diagnoses:
R29.898 (ICD-10-CM) - Right leg weakness

Provider:
BELLEVUE HEALTHCARE II
2015 152nd Ave NE
Redmond WA 98052-5521

Facility:
BELLEVUE HEALTHCARE - LIBERTY LAKE
23102 E APPLEWAY AVE
LIBERTY LAKE WA 99019-9585

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If you have additional questions or concerns, please contact us for further assistance.

Molina's customer service department can be reached at 1-800-869-7165.

Best regards,

Michael J Sikora and Your Health Care Team

Kaiser Permanente
(866) 691-2559

Patient Record Information

Please be aware that you can retrieve patient information including referral requests on our electronic Epic Affiliate Link provider portal through One Health Port. Visit the weblink below for additional help with using Epic Affiliate Link via One Health Port and requesting elevated patient chart access:

https://wa-provider.kaiserpermanente.org/communications/site-enhancements

If you require additional medical records beyond what is provided on the Continuity of Care document, please obtain them as follows:

- **Electronic Records** – Visit **Epic Care Everywhere** or **Epic Affiliate Link** via One Health Port
- **If unable to access records electronically** – Contact the Kaiser Permanente Release of Information Office in your area:

  Western Washington Release of Information
  Phone: 206-630-6848 or 1-866-656-4184
  Fax: 206-630-6849

  Eastern Washington Release of Information
  Phone: 509-241-7824
  Fax: 509-232-3127

  For radiology imaging requests ONLY
  (X-rays, MRI scans, CT scans, etc.)
  Central Imaging Center - Capitol Hill Campus
  Phone: 206-326-3715
  Fax: 206-326-2007

  (Note: please do not submit referral requests to the Release of Information departments, as referrals are not processed by these teams)

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Type	Date	User	Summary	Attachment
External OAL Notification	01/13/2025 12:51 PM	Deishl, Sonja	Auto: 19525-KPWA RFL MESSAGE TEXT	Document on 1/13/2025 12:50 PM by Deishl, Sonja: Referral Notification Document

Note:
Referral Notification

Type	Date	User	Summary	Attachment
DME Process Complete	01/13/2025 12:51 PM	Deishl, Sonja	DME Process:Action taken: No action needed	-

Note:
DME Process:Action taken: No action needed

Type	Date	User	Summary	Attachment
External Member Referral Letter	01/13/2025 12:50 PM	Deishl, Sonja	Auto: 31649-PATIENT EXT REF LETTER - MOLINA - REF PLACE OF SERVICE	-

Note:

RS

KAISER PERMANENTE®
Kaiser Foundation Health Plan of Washington
LIDGERWOOD HEALTH CARE CENTER
6002 N Lidgerwood St
Spokane, WA 99208-1124

January 13, 2025

Alisha M Meyer
Apt 14
10311 E 14th Ave
Spokane Vly WA 99206

Dear Alisha M Meyer:

You have been referred by Michael J Sikora to see a specialist in Durable Medical Equipment listed below:

Provider:
BELLEVUE HEALTHCARE II
2015 152nd Ave NE
Redmond WA 98052-5521

Facility:
BELLEVUE HEALTHCARE - LIBERTY LAKE
23102 E APPLEWAY AVE
LIBERTY LAKE WA 99019-9585
509-532-7779

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Please call and schedule an appointment with the specialist office noted above.

This letter is not a guarantee of payment or authorization from your healthcare insurance. Contact your insurance carrier, Molina Healthcare at 1-800-869-7165, if you have questions about your benefit coverage for these referred services and to verify the specialist is in-network with your plan.

If you have additional questions or concerns, please contact us for further assistance.

Best regards,

Michael J Sikora and Your Health Care Team

Kaiser Permanente
(866) 691-2559

Type	Date	User	Summary	Attachment
No Carrier Authorization Required	01/13/2025 12:50 PM	Deishl, Sonja	Pre-authorization not required	-

Note:
Pre-authorization not required
Insurance:Molina
Procedure/CPT Code or J Code:
Additional Comments:

Type	Date	User	Summary	Attachment
Provider Comments	01/13/2025 11:56 AM	Sikora, Michael J, MD	Provider Comments	-

Note:
Enter other order details here:

Wt Readings from Last 1 Encounters:
01/13/25 : 193 lb (87.5 kg)

Ht Readings from Last 1 Encounters:
01/13/25 : 5' 0.5" (1.537 m)

Referral Order

Order
REF DME CANES (Order # 472533395) on 01/13/2025

Questionnaire

What type of service is being requested?	None of the Above

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Type of Request
What is being ordered?
Has the patient been diagnosed with an infection or injury of the perineal area and the sitz bath is part of a planned regimen of home care treatment?
Is the patient confined to a bed?
What type of brace is being ordered?
Select the device being ordered:
Does the patient have a nonunion of a long bone fracture defined as radiographic evidence that fracture healing has ceased for three or more months prior to starting treatment with the osteogenesis stimulator?
Does the patient have a failed fusion of a joint other than in the spine where a minimum of nine months has elapsed since the last surgery?
Does the patient have congenital pseudarthrosis?
Has the patient had a failed spinal fusion where a minimum of nine months has elapsed since the last surgery?
Has the patient had a multilevel spinal fusion surgery?
Has the patient had a failed spinal fusion surgery where there is a history of a previously failed spinal fusion at the same site?
Does the patient have a nonunion fracture and a minimum of 2 sets of radiographs prior to treatment with the osteogenesis stimulator?
Are the radiographs separated by a min of 90 days with each including multiple views of the fracture site, and has a written interpretation stating no clinically significant evidence of fracture healing between the two sets or radiographs?
Is the fracture at a site other than the skull or vertebrae?
Is the fracture not related to a tumor?
Has the patient had a total knee replacement?
Is this device being prescribed for use, nor more than two days from the surgery date and for no longer than 3 weeks post surgery?

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Is this being prescribed for treatment of contractures?
Has the patient had a recent injury or surgery that requires both medial and lateral rotation control?
Does the patient have documented knee instability/joint laxity?
What device is being ordered?
Does the patient have weakness or deformity of the foot and ankle?
Does the patient require stabilization for medical reasons?
Does the patient have the potential to benefit functionally?
Does the patient require knee stability?
Does the patient have plantar flexion contracture of the ankle with dorsiflexion on passive range of motion testing of at least 10 degrees?
Is there a reasonable expectation of the ability to correct the contracture?
Is the contracture interfering or expected to interfere significantly with the patient's functional abilities?
Is this going to be used as a component of a therapy program which includes active stretching of the involved muscles and/or tendons?
Does the patient have plantar fasciitis?
Does the patient have weakness or deformity of the knee that requires stabilization?
Has the patient had a recent injury to or a surgical procedure on the knee?
Is the patient ambulatory and has knee instability?
Is the examination of the patient's joint laxity documented?
Does the patient have flexion or extension contractures of the knee with movement on passive range of motion testing of at least 10 degrees?
Is the need for a custom fabricated orthosis instead of a prefabricated orthosis documented?
Is this to reduce pain by restricting mobility of the trunk?
Is this to facilitate healing following an injury to the spine or related soft tissues?
Is this to facilitate healing following a surgical procedure on the spine or

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related soft tissue?
Is this to support weak spinal muscles and/or deformed spine?
Has the patient had a mastectomy?
Has the patient had breast reconstruction?
Does the patient have a mastectomy form or silicone (or equal) breast prosthesis?
Does the patient have a mastectomy form?
Will the external breast prosthesis garment be used in the post-operative period prior to a permanent breast prosthesis or will it be used as an alternative to a mastectomy bra and breast prosthesis?
Does the member have a mobility limitation that significantly impairs their ability to participate in one or more mobility-related activities of daily living (MRADL) in the home?
Will the functional mobility deficit be sufficiently resolved by the use of the cane or crutch, and is the patient able to safely use a cane or crutch?
Does the patient have a documented episode of ventricular fibrillation or a sustained, lasting 30 seconds or longer, ventricular tachyarrhythmia?
Does the patient have familial or inherited conditions with a high risk of life-threatening ventricular tachyarrhythmia such as long QT syndrome or hypertrophic cardiomyopathy?
Does the patient have either documented prior myocardial infarction or dilated cardiomyopathy and a measured left ventricular ejection fraction less than or equal to 0.35?
Does the patient need to have a previously implanted defibrillator explanted?
Does the patient have a diagnosis of Diabetes Mellitus?
Within the last 6 months, has the patient had an in-person, video, or telephone visit with a physician, NP, or PA to evaluate their diabetes control?
Has the patient's treating practitioner concluded the patient (or the patient's

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caregiver) has training using the particular device prescribed as evidenced by providing a prescription for the appropriate supplies and frequency of blood glucose testing?	
Is the patient insulin treated?	
Does the patient have recurrent (more than one) level 2 hypoglycemic events (glucose <54mg/dL (3.0mmol/L)) that persist despite multiple (more than one) attempts to adjust medication(s) and/or modify the diabetes treatment plan?	
Does the patient have a history of one level 3 hypoglycemic event (glucose <54mg/dL (3.0mmol/L)) characterized by altered mental and/or physical state requiring third-party assistance for treatment of hypoglycemia	
Is the patient physically incapable of utilizing a regular toilet for at least one of the following situations: 1) confined to a single room, 2) confined to one level where there is no toilet, or 3) the home has no toilet facility?	
Bilateral or Lateral?	
Will the compression burn garment be used to treat hypertrophic scarring and joint contractures following a burn injury?	
Is this being requested to treat a wound caused by or treated by a surgical procedure or following a debridement or open venous stasis ulcer?	
For non-surgical wounds, was any type of debridement (surgical, enzymatic, mechanical, biological, autolytic) ever performed on this wound?	
Select all that apply for the members condition that this item is being requested for:	
Member has venous or lymphatic condition, as indicated by 1 or more of the following:	
CPAP or BIPAP request?	
Does the patient have any of the following? (Hover for info)	
Has the diagnosis been confirmed by polysomnography, either during an inpatient hospital visit or sleep lab, or	

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was OSA suspected at the time of discharge?	
Does the patient use on average 4 hours per night for a minimum of 70% of nights?	
Has there been a re-evaluation by the treating provider within 30-90 days from the initial request with documentation that includes symptoms of OSA are improved; and evidence of adherence to use of the device?	
What is being ordered?	
Is there record of the patient's need for a pump (i.e. gravity feeding is not satisfactory due to reflux or aspiration, severe diarrhea, dumping syndrome, administration rate less than 100 ml/hr, glucose fluctuations, gastrostomy/jejunostomy tube used)?	
What is the Administration/Delivery Method?	
Does the patient have full or partial non-function or disease of the structures that normally permit food to reach the small bowel, that will last at least 3 months?	
Does the patient have a disease that impairs digestion and/or absorption of an oral diet, directly or indirectly, by the small bowel, that will last at least 3 months?	
Does the patient's medical record include documentation stating why a standard formula cannot be used?	
What type of Device or Supply is being ordered?	
Does the patient have a covered cochlear implant or a bone-anchored hearing aid (BAHA)?	
Is this request for convenience or to upgrade to a newer technology?	
Is the current component obsolete or no longer supported?	
Is the current component no longer meeting the patient's needs?	
Has the patient had a formal evaluation of their cognitive and communication abilities by a speech-language pathologist (SLP)?	
Does the patient's medical condition result in a severe expressive speech impairment?	

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Can the patient's speaking needs be met using natural communication methods?	
Have other forms of treatment been considered and ruled out?	
Will the patient's speech impairment benefit from the speech generating device?	
Does the treating practitioner have a copy of the SLP's written evaluation and recommendation?	
Does the patient have an absence or shrinkage of an eye due to a birth defect, trauma, or surgical removal?	
Has the patient had more than 2 eye polishing services within this year?	
What is being ordered?	
Is the patient using a covered insulin pump?	
Does the patient vhave Diabetes Mellitus?	
Does the patient have C-Peptide level <110% (or has renal insufficiency w/C-peptide level <200%) & fasting sugar drawn at the same time <225 mg/dl?	
Does the patient have a positive Beta cell autoantibody test?	
Has the patient completed comprehensive diabetes education program, multiple daily insulin injections (3/day), frequent self-adjustments of insulin dose for at least 6 months, has documented glucose self-testing at least 4x/day during the 2 months prior?	
Does the patient have HbA1c>7%, or history of recurring hypoglycemia, or wide fluctuations in blood glucose before mealtime, or "Dawn phenomenon" w/fasting blood sugars frequently >200mg/dL, or history of sever glycemic excursions?	
Has the patient been on an insulin pump prior to enrollment with plan and has documented frequency of glucose self-testing at least 4x/day (on average) during the month prior to enrollment?	
Does the patient have a medical condition that requires positioning of the body in ways not feasible with an ordinary bed due to pain, CHF, or chronic pulmonary disease?	

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Does the patient have aspiration problems requiring head of bed elevation >30 degrees and have a need for frequent changes in body positions, and/or an immediate need for a change in body position?
Does the patient require traction equipment requiring attachment to a hospital bed?
Are Hospital Bed accessories or a replacement mattress needed?
Type of Accessories:
Is this being provided for a patient-owned Hospital Bed?
Does the patient require a trapeze to sit up because of a respiratory condition, to change body positions for other medical reasons, or to get in and out of bed?
Does the patient have a condition that requires a safety enclosure that would be an integral part of a hospital bed?
Is a bed cradle needed to prevent the patient from having contact with the bed coverings?
Does the patient have a condition that requires bed rails?
Is the patient confined to a bed?
Does the patient's condition require a replacement mattress?
Is this request for a Negative Pressure Wound Therapy pump or supplies?
Does the patient have a chronic stage 3 or 4 pressure ulcer, a neuropathic ulcer, venous or arterial insufficiency ulcer, or a chronic (being present for at least 30 days) ulcer of mixed etiology?
Has the patient been appropriately turned and positioned, and has used a group 2 or 3 support surface, and has had their moisture and incontinence appropriately managed?
Has the patient been on a comprehensive diabetic management program and has reduction in pressure on a foot ulcer been accomplished?
Has the patient had compression badages and/or garments cosistnetly applied and have leg elevation and ambulation been encouraged?
Has wound therapy, with documented eval, care, & wound measurement by a medical professional, dressings to

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maintain a moist wound area, debridement of necrotic tissue, & provisions for adequate nutritional status been tried or considered & ruled out?	
Does the patient have an ulcer or wound found in an inpatient setting, and after wound treatments have been tried or considered & ruled out, Negative Pressure Wound Therapy is used because the treating practitioner determines it is the best treatment?	
Does the patient have complications of a surgically created wound or a traumatic wound where there is documentation of medical necessity for an accelerated formation of granular tissue which cannot be achieved by other available topical wound treatments?	
Is the patient currently using a Negative Pressure Would Therapy pump?	
Does the patient have angina pectoris in the absence of hypoxemia, dyspnea without cor pulmonale or the evidence of hypoxemia, severe peripheral vascular disease resulting in clinically evident desaturation in one or more extremities but the in absence of systemic hypoxemia, or a terminal illness that does not affect the ability to breathe?	
The patient had a qualifying blood gas, performed by a treating practitioner or qualified provider during the patient's illness or within 2 days of discharge from a hospital (documented) & the provision of oxygen, in the home setting, will improve the condition?	
Does the patient have an arterial PO2 at or below 55 mm Hg or an arterial oxygen sat at or below 88% taken at rest (awake) while breathing room air?	
Does the patient have an arterial PO2 at or below 55 mm Hg, or an arterial oxygen sat at or below 88 %, taken during sleep for a patient who demonstrates an arterial PO2 at or above 56 mm Hg or an arterial oxygen sat at or above 89% while awake.	
Does the patient have a decrease in arterial PO2 more than 10 mm Hg, or a decrease in arterial oxygen sat more	

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than 5% from baseline sat, taken during sleep and associated with symptoms of hypoxemia?
Does the patient have an arterial PO2 at or below 55 mm Hg or an arterial oxygen sat at or below 88%, taken during exercise for a patient who demonstrates an arterial PO2 at or above 56 mm Hg or an arterial oxygen sat at or above 89% while at rest?
Does the patient have an arterial PO2 of 56-59 mm Hg or an arterial blood oxygen saturation of 89 percent?
Does the patient have dependent edema suggesting CHF, pulmonary hypertension or cor pulmonale, determined by measure of pulmonary artery pressure, gated blood pool scan, echocardiogram, or "P" pulmonale on EKG, or Erythrocythemia with a hematocrit > 56%?
Does the patient have the absence of hypoxemia and a medical condition with distinct physiologic, cognitive, and/or functional symptoms documented in high-quality, peer-reviewed literature to be improved by oxygen therapy?
Oxygen Saturation or PaO2 level:
Measurement:
Date of oxygen saturation or PaO2 level measurement:
Testing Conditions:
Describe needed change:
Type of Pad or Mattress?
Is the patient completely immobile (i.e., the member can't make changes in the body position without assistance?
Does the patient have limited mobility (i.e., the member can't make changes in body position significant enough to alleviate pressure)?
Does the patient have one of these conditions; impaired nutritional status, fecal or urinary incontinence, altered sensory perception, or compromised circulatory status?
Does the patient have any stage pressure ulcer on the trunk or pelvis?
Does the paitient have multiple stage 2 pressure ulcers located on the trunk

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or pelvis which have failed to improve over the past month?	
Has the patient been on an ulcer treatment program including, a Group 1 support surface, assessment by a licensend healthcare professional, turning and positioning, wound care, moisture/incontinence control, nutritional assessment and invtervention?	
Does the patient have large or multiple stage 3 or 4 pressure ulcer(s) on the trunk or pelvis?	
Has the patient had a myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis in the past 60 days and has been on a Group 2 or 3 support surface immediately prior to discharge from a hospital or nursing facility in the past 30 days?	
What type of Patient Lift or Transfer Device is being ordered?	
Does the patient need to be transferred between a bed and a chair, wheelchair or commode?	
Without the use of a lift, would the patient be conifined to a bed?	
Is this sling or seat being ordered as a replacement for a covered lift?	
Does the patient have severe arthritis of the hip or knee or have a severe neuromuscular disease?	
Is the seat lift mechanism being prescribed to effect improvement, or arrest or retard deterioration in the patient's condition?	
Is the patient completely incapable of standing up from a regular armchair or any chair in their home?	
Once standing, does the patient have the ability to ambulate?	
Have all appropriate therapeutic modalities to enable the patient to transfer from a chair to a standing position been tried already?	
What type of Pneumatic Compression is being ordered?	
Does the patient have lymphedema?	
Does the patient meet one or more of the following criteria (Check all that apply)	
Is the patient's lymphedema documented to be unresponsive to	

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other clinical treatment over the course of a required four-week trial?	
Does the patient have chronic venous insufficiency with venous stasis ulcers of the lower extremity?	
Does the patient have all of the following: edema in the affected lower extremity; one or more venous stasis ulcer(s); the ulcer(s) have failed to heal after a six-month trial of conservative therapy directed by the treating practitioner?	
Does the member have lymphedema extending onto the chest, trunk and/or abdomen that extends past the limits of a standard compression sleeve?	
Has the chest, trunk and/or abdominal lymphedema has failed to improve with a four-week trial?	
What is being ordered?	
Is this being ordered as a replacement piece to a covered wheelchair?	
Does the patient have a mobility limitation that limits their ability to participate in one or more MRADLs within the home and that limitation cannot be resolved with a cane or walker?	
Does the patient have sufficient upper extremity function to self propel a manual wheelchair in the home to perform MRADLs?	
Has the patient had a face to face visit in the last 6 months?	
Is this being ordered for use with a covered brace?	
Does the patient have chronic obstructive lung disease, chronic bronchitis, or emphysema?	
Does the patient have a neuromuscular disease?	
Is the patient's condition causing a significant impairment of chest wall and/or diaphragmatic movement, such that it results in an inability to clear retained secretions?	
Has the patient or caregiver received appropriate training by a physician or therapist?	
Request Type:	
Does the patient have Diabetes Mellitus?	

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Does the patient have 1 or more of these conditions; amputation of other foot or partial of either foot, previous foot ulceration, pre-ulcerative callus, peripheral neuropathy with callus formation, foot deformity, or poor circulation, either foot?	
Has the patient had a face to face visit with the provider managing their diabetes care (and the members conditions are documented in their medical record), within 6 months of this order?	
Does the patient have a foot deformity that cannot be accommodated by a depth shoe?	
Is this to be used as part of a covered leg brace and is medically necessary for the propoer functioning of the brace?	
Is this prosthesis being used by the patient for treatment or rehab during an inpatient stay?	
Is this prosthesis reasonable and necessary for use by the patient in their home setting?	
Is this prosthesis being delivered to the patient no more than 2 days prior to a discharge from an inpatient stay, or to a patient who is not currently inpatient?	
Does the patient use of a respiratory suction pump to clear secretions?	
Does the patient have a tracheostomy?	
Is the patient on a ventilator?	
Does the patient have an orthopedic impairment requiring traction equipment which prevents ambulation during the period of use?	
Does the patient have a muskuloskeletal or neurological impairment requiring cervical traction equipment?	
Has the patient had demonstration of appropriate use of home cervical traction device and tolerated use?	
Does the patient meet one or more of the following criteria (Check all that apply)	
Does the patient have neuromuscular disease and chronic respiratory failure consequent to chronic obstructive pulmonary disease?	

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Does the patient have thoracic restrictive diseases and chronic respiratory failure consequent to chronic obstructive pulmonary disease?
Request Type?
Does the patient have a full thickness wound, wound with light to moderate exudate, or a wound that has stalled or has not progressed toward a healing goal?
Does the patient have a wound with heavy exudate, a third dgree burn, or active vasculitis?
Does the patient have a moderate to highly exudative full thickness wound or wound cavity?
Is the patient's wound covered with eschar?
Is the gauze being used for dressing changes no more than 3 times per day for a dressing without a border and once per day for a dressing with a border?
Does the patient have a full thickness wound with minimal or no exudate?
Does the patient have a stage 2 ulcer?
Does the patient have a wound with light to moderate exudate?
Does the patient have an open, partial thickness wound with minimal exudate or a closed wound?
Is this being used to hold wound cover dressings in place?
Is this patient currently receiving Home Health Care?
Type of Walker or Gait Trainer?
Does the patient have a mobility limitation that significantly impairs the ability to participate in one or more mobility-related activities of daily living (MRADL), and will the deficit be resolved by the use of the device, and can the patient safely use the device?
Is the patient unable to use a standard walker due to a severe neurologic disorder or other condition causing the restricted use of one hand?
Are Walker Accessories needed?
Type of Accessories:
Is this being provided for a patient - owned walker?

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Type of Request:
Can the patient's mobility limitation be sufficiently resolved by the use of an appropriately fitted cane or walker?
Does the patient's home provide adequate access between rooms, manuevering space, and surfaces for use of a manual wheelchair?
Does the patient have a mobility limitation that impairs their ability to participate in mobility-related activities of daily living (MRADLs) entirely?
Does the patient have a mobility limitation that impairs their ability to complete MRADLs in a reasonable time frame?
Does the patient have a mobility limitation that impairs their ability to participate in MRADLs and would put them at heightened risk of morbidity or mortality secondary to the attempts to perform the MRADLs?
Will use of a manual wheelchair significantly improve the patient's ability to participate in MRADLs and will they have expressed that they will use it on a regular basis in the home?
Does the patient have sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel in a manual wheelchair?
Does the patient have a caregiver who is available, willing, and able to provide assistance with the wheelchair?
Does the patient require a lower seat height (17-18") because of short stature or to enable them to place their feet on the ground for propulsion?
Is the patient able to self-propel in a lightweight wheelchair, but cannot in a standard wheelchair?
Is the patient able to self-propel the wheelchair while engaging in frequent activities in the home that cannot be performed in a standard or lightweight wheelchair?
Does the patient spend at least 2 hours per day in the wheelchair and require a seat width, depth, or height that cannot be accommodated in a standard or lightweight chair?

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Does the patient have severe spasticity?	
Does the patient have sufficient strength and postural stability to utilize a Rollabout chair?	
Has the patient had an evaluation performed by a licensed/certified medical professional (LCMP), who has specific training and experience in rehab wheelchair evaluations and that documents the medical necessity and it's special features?	
Is the wheelchair being provided by a Rehabilitative Technology Supplier that employs a RESNA-certified Assistive Technology Professional who specializes in wheelchairs and who has direct, in-person involvement in the chair selection for the patient?	
Place Of Delivery:	
Alternative Business Name:	
Alternative Address Line 1:	
Alternative Address Line 2:	
Alternative City:	
Alternative State:	
Alternative ZIP Code:	
Alternative Phone:	
Patient Height (in):	
Patient Weight (lbs):	
Ok to substitute an in network provider if the chosen referred to provider is not in the member's network?	
Is this a retrospective request?	
Name of Requestor:	
Requestors Contact #:	
Referral Quality Issues	
Other (please describe)	

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