Print Form

CalOptima
A Public Agency
Better. Together.

Custom Wheelchair Evaluation Request

Information to accompany Clinical Questionnaire

Fax information to CalOptima at 714-481-6516

MEMBER INFORMATION

Patient Name: _____ Date of Birth: _____ Age: _____
(First) (MI) (Last)

Medi-Cal Number (CIN): _____ Gender: ☐ Female ☐ Male Phone: _____

Patient Address: _____ City: _____ ZIP: _____

☐ Home ☐ Board and Care ☐ ICF-DD SNF ☐ Other: _____

Facility Name: _____ Contact: _____

Language: Patient Speaks: _____ Patient Understands: _____

Caregiver / Family member participating in assessment and fitting ☐ YES ☐ NO ☐ N/A If yes, language spoken: _____

Transportation: ☐ Self / Family / Caregiver ☐ Public **OR** Medically necessary: ☐ Medivan ☐ Littervan ☐ Basic Ambulance

PRESCRIPTION

(Rx must be completed, signed, and dated by attending physician.)

Prescribing Physician _____

Medi-Cal Provider ID # _____

Phone: _____ Fax: _____

Address _____

Primary Care Physician (PCP): _____

Medi-Cal Provider ID # _____

Phone: _____ Fax: _____

Address _____

Primary Dx: _____ ICD-10: _____ Current Functional Status: _____

Current Wheelchair: ☐ YES ☐ NO If "YES": ☐ Manual ☐ Power ☐ Tilt/Recline Year: _____ Serial #: _____

Custom DME Prescribed: ☐ Therapeutic Cushion ☐ Manual Wheelchair ☐ Power Wheelchair ☐ Not Specified

M. D. Signature: _____ Date: _____

Preferred Vendor: _____

(If provider or member does not designate, CalOptima will assign DME vendor.)

AUTHORIZATION *(For CalOptima Use Only)*

Eligibility Date: _____ Health Network: _____ Other Health Coverage: Medicare N/A

Utilization Contact: _____ Phone: _____ FAX: _____

Approved Codes:

- ☐ S100C & S200C (Therapeutic Seat Cushion and/or Positioning System & Post Delivery Assessment/Fitting)
- ☐ S101C & S201C (Custom Foam/Molded Cushion & Post Delivery Assessment Fitting)
- ☐ S 102C & S202C (Manual Wheelchair With or Without Therapeutic Cushion & Post Delivery
- ☐ S103C & S203C (Manual Wheelchair With Positioning System, With or Without Therapeutic Cushion & Post Delivery Assessment/Fitting
- ☐ S 104C & S204C (Power Wheelchair With or Without Therapeutic Cushion & Post Delivery
- ☐ AS105C & S205C t/Fitti) (Power Wheelchair With Power Tilt/Recline or Specialized Driving Controls & Post Delivery
- ☐ S300C & S301C (In-home assessment by DME Assessment Provider & Post Delivery Assessment/Fitting)

Approved Provider: _____

Authorization #: _____ Date Approved: _____ Date Sent: _____ By: Fax Mail

Records Attached: Progress Notes H&P Therapy Notes Operative Report Acute/LTC Facility Notes Previous Equipment Repairs

Denied M.D. Signature: _____ Date: _____