CalOptima Health

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 Health 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: ______________