Wheelchair Repair/Modification Form

Medical documentation by the prescribing practitioner must be submitted to support that the recipient has ongoing medical necessity for the item needing repair. This Wheelchair Repair/Modification Form must be filled out completely or it and the prior authorization request will be pended for more information and/or denied. A manufacturer's invoice may be required to substantiate payment by Medicaid per PT 33 fee schedule, and an unaltered complete order form specific to the manufacturer and model of the items being requested must be attached. DME providers are required to educate the recipients on the proper use of durable medical equipment. Per Nevada Medicaid policy, intentional utilization of DME in a manner not prescribed or recommended, such as an excessive form of transportation, may be reason for denial of equipment replacement.

For **questions** regarding this form, call: (800) 525-2395

DATE OF REQUEST: _____ /_____ /_____

NOTES:

RECIPIENT INFORMATION

Recipient Name (Last, First, MI):		
Recipient Medicaid ID:	Date of Birth:	Phone:

PROVIDER INFORMATION

Name of DME company:	NPI:
Fax:	Phone:

WHEELCHAIR INFORMATION

Is this request for Healthy Kids (EPSDT) services? ☐ Yes ☐ No

REQUIRED FOR INPATIENT PATIENTS AND PATIENTS BEING DISCHARGED FROM A FACILITY:

Enter date of discharge or anticipated date of discharge (as MM/DD/YYYY): _____

Provide discharge documents with date from the facility.

1. Make:_____ Model:_____ Serial #:_____

2. Miles/Hours reading #:_____ Age of Equipment in months:_____

   Initial Dispense Date:_____

3. Name of person/company/entity who purchased wheelchair_____

   If Nevada Medicaid did not purchase the wheelchair, the recipient must meet current qualifications for the item. Any assessment(s) necessary to support medical necessity must have been completed within six months of the date of request.

4. Is the wheelchair within Manufacturer's Warranty? ☐ Yes ☐ No

   Please submit a copy of the warranty information.

5. Is this request for a modification? ☐ Yes ☐ No

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Recipient Name (Last, First, MI):	Date of Request:

6. Name of manufacturer of replacement parts: _____

7. What was the initial complaint from the recipient that prompted the evaluation?

8. How did the wheelchair come into disrepair? (If normal wear and tear please explain in complete detail the normal daily/weekly schedule of recipient's use of this equipment.)

9. Please provide the service repair documentation from the technician describing the steps taken to determine need and what was found during the wheelchair evaluation. Include previous repairs and dates of service of repairs.

10. Itemize all parts requiring replacement and their cost in the table on page 3 of this form. If additional lines are needed, please download additional tables. Estimate the cost of labor.

CERTIFICATION

I HEREBY CERTIFY that by signing and submitting this report that the information may be relied upon for the accurate determination of need for repairs.

I certify that all submitted data on this form is true and accurate. *Knowingly adding incorrect information or failing to disclose pertinent information is considered fraud and will be treated as such.*

TECHNICIAN OR DME PROVIDER:

Signature:_____

Printed Name:_____ Signature Date:_____

Phone Number:_____

This authorization request is not a guarantee of payment. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program. The information on this form and on accompanying attachments is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If this communication is received in error, the reader shall notify sender immediately and destroy all information received.

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Recipient Name (Last, First, MI):	Date of Request:

In the table below, use column 1 to enter the HCPCS code. Check column 2 and utilize miscellaneous codes if no HCPCS code is assigned from PDAC for the item being requested. Use column 3 to enter a description of the item. Enter the appropriate modifier and number of requested units in columns 4 and 5. In column 6, enter “R” if the equipment is for repair and “M” if the equipment is for modification. If the item is covered by Medicare, enter a “Y” in column 7. If the item is not covered by Medicare, enter an “N” in column 7.

1	2	3	4	5	6	7
HCPCS CODE	No HCPCS code	DESCRIPTION	MODIFIER	UNITS	"R" or "M"	MEDICARE Y or N
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