



**MOBILITY EVALUATION FORM WHEELCHAIR**  
**(Fee-for-Service (FFS) Program Only – Not for Managed Care Program Use)**

**Pursuant to He-W 571.05(c), requests for all wheelchairs, scooters, and customized strollers must (in addition to Form 272D) include a completed Form 272M, “Mobility Evaluation Form Wheelchair”**

This evaluation must be completed by a New Hampshire licensed Physician, Occupational Therapist, or Physical Therapist specializing in rehabilitation medicine. Evaluator must have a broad knowledge of the various seating systems and wheelchairs available in today’s market. **NOTE:** Requests for standard/non-customized manual wheelchairs do not require the completion of this form by a Physician or OT/PT; a Rehabilitation Specialist may complete the form.

**RECIPIENT INFORMATION**

RECIPIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
RECEPIENT HEIGHT: \_\_\_\_\_ RECIPIENT WEIGHT: \_\_\_\_\_  
RECIPIENT MEDICAID ID #: \_\_\_\_\_ DIAGNOSIS CODES: \_\_\_\_\_  
ALTERNATE INSURANCE: NAME OF PLAN \_\_\_\_\_  
DATE OF EVALUATION: \_\_\_\_\_

**PROVIDER/EVALUATOR INFORMATION**

CONTACT: \_\_\_\_\_ EMAIL: \_\_\_\_\_  
TELEPHONE #: \_\_\_\_\_ Ext: \_\_\_\_\_ FAX #: \_\_\_\_\_  
PERFORMING FACILITY: \_\_\_\_\_ PERFORMING FACILITY MEDICAID ID #: \_\_\_\_\_  
EVALUATOR: \_\_\_\_\_ EVALUATOR MEDICAID ID# \_\_\_\_\_  
EVALUATOR EMAIL: \_\_\_\_\_ EVALUATOR TELEPHONE #: \_\_\_\_\_  
DIAGNOSIS (written, not ICD codes) PRIMARY: \_\_\_\_\_  
SECONDARY: \_\_\_\_\_

**If this recipient has had multiple seating systems in the past three (3) years, or surgical procedures are anticipated, or growth or physical deterioration may limit recipient’s ability to utilize the proposed seating system for less than five (5) years, then the recipient must be evaluated for an “adjustable growth” seating system that would accommodate any foreseeable changes.**

**CURRENT AMBULATORY STATUS**

Please address the following: Would the recipient be confined to a bed if a wheelchair were not provided? Is the recipient able to use a walker, cane, or walk with assistance? What is the distance the recipient is able to ambulate without assistance?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_





**RECIPIENT'S HISTORY:**

Vision: \_\_\_\_\_

Cognition: \_\_\_\_\_

Ability to Communicate: \_\_\_\_\_

Daily Activity Level: \_\_\_\_\_

Mobility Evaluation (strength/tone/contractures etc.): \_\_\_\_\_

Anticipated Surgical Procedures/Orthotics: \_\_\_\_\_

Other Special Considerations: \_\_\_\_\_

**INDICATE WHICH LESS COSTLY WHEELCHAIRS/SEATING SYSTEMS HAVE BEEN CONSIDERED AND WHY THEY WOULD NOT BE APPROPRIATE TO MEET THIS RECIPIENT'S NEEDS. (attach additional comments as necessary)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**TO BE COMPLETED BY PERSON PERFORMING THE EVALUATION**

**RECOMMENDED CHAIR**

Make: \_\_\_\_\_

Model: \_\_\_\_\_

**THE FOLLOWING OPTIONS ARE MEDICALLY NECESSARY:**

<u>Option</u>	<u>Justification</u>
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____
8. _____	_____
9. _____	_____
10. _____	_____
11. _____	_____
12. _____	_____
13. _____	_____
14. _____	_____
16. _____	_____
17. _____	_____
18. _____	_____
19. _____	_____
20. _____	_____
21. _____	_____
22. _____	_____
23. _____	_____
24. _____	_____
25. _____	_____



**RECOMMENDED CHAIR**

Make: \_\_\_\_\_ Model: \_\_\_\_\_

**Check all that apply. Indicate N/A if not applicable:**

- Will allow access to recipient's home
- Will allow access to school/place of employment
- Will meet van/bus/other transportation methods recipient currently needs
- Will meet recipient's mobility needs
- Potential growth of recipient has been taken into consideration in selecting the size of chair so that it may provide at least **five (5) years of use**
- Recipient's caregivers are familiar with care /maintenance/operation of this chair
- Recipient has demonstrated proficiency in the safe operation of this chair
- Less costly chairs have been ruled out as inappropriate
- This chair will accommodate recipient's respiratory equipment and other special needs

**SUMMARY / COMMENTS**

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\_\_\_\_\_  
Signature of physician, licensed therapist completing the evaluation

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name and title of physician, licensed therapist completing the evaluation

**RECIPIENT, PARENT OR LEGAL GUARDIAN** (please check the statement that applies)

- I **accept** the recommendations for the make, model and options of the equipment being requested and acknowledge that the safe operation and benefits of the equipment's options and features have been fully explained to me. I have no questions or concerns regarding the recommendations made.
- I **do not agree** with all of the recommendations and I request changes based on the following:

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\_\_\_\_\_  
Signature of Recipient/Parent/Legal Guardian

\_\_\_\_\_  
Printed Name and Relationship

\_\_\_\_\_  
Date



**WHEELCHAIR SUPPLIER** (Please check all of the following statements that apply. If a statement does not apply, please state why they do not apply in the comments section below)

- I concur with the recommendations made, and I am unaware of any other less costly wheelchairs or options in the market at this time that would meet this recipient's needs.
- The recipient  **is**  **is not** a nursing facility resident or awaiting placement to a nursing facility.
- The recipient is a nursing facility resident but is awaiting discharge.
- To the best of my knowledge, the recipient  **has**  **has not** received, nor is expected to receive, a wheelchair (seating system) from other sources.
- To the best of my knowledge, the recipient  **does**  **does not** have insurance or funding sources for this seating system.
- The chair being requested  **is**  **is not** a backup seating system to any current mobility system the recipient now has or is expected to obtain.
- Any and all components (i.e. cushions, trays, headrests) that can be utilized from the recipient's current wheelchair will be placed on the new wheelchair.
- I have visited the recipient's home and have verified that the home may be accessed using this wheelchair (including bedroom, bath, and other living spaces as needed).
- I recommend consideration of the equipment changes as listed below:

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By signing below, the selected wheelchair vendor acknowledges that the NH Medicaid payment for the wheelchair to the vendor is **inclusive** of the following services: 1. **Delivery** and assembly of the chair; 2. **Explanation** as to the proper care and preventive maintenance of the chair; 3. **Demonstration** as to the chair's proper operating procedure; and 4. Any necessary **follow-up for training** and/or **adjustments** required for the chair within 30 days following the delivery of the chair.

Signature of DME Vendor	Date
Printed Name of DME Vendor	Name of agency