Mobility Assistive Equipment (MAE)

Prior Authorization Form

Please Fax To: (952) 853-8714 **For Questions Call: (888) 467-0774**

Member Name:	**Vendor:**
Member ID#:	**Vendor Address:**
DOB:	**Tax ID#:**
	Vendor Phone #:
Form Completed By:	**Date Completed:**

This form needs to be completed by a Health Professional (MD, PT, etc), not a Vendor. When completed, please fax to Vendor. Vendor: Please fax completed form to (952) 853-8714 for authorization.

Device Requested:

☐ Manual Wheelchair ☐ Electric Wheelchair ☐ Scooter ☐ Stroller

Ordering Practitioner:_____ Phone: _____ Fax:_____

Prior Approval Requirements:

- ***Manual Wheelchair –*** *Face to face examination with physicians is* ***not*** *required*
- ***Electric Wheelchair, Scooter / POV –*** *Face to face physician examination* ***is required*** *within 45 days of ordering any of these devices.*

Mobility-related activities of daily living (MRADL's: eating, dressing, grooming, toileting and bathing performed in customary locations.

Current Symptoms, Related Diagnoses, and History

Describe the reason for the MAE:

Height:	**Weight:**	**Neck, Trunk and Pelvic Posture and Flexibility**: _____ Good _____ Limited _____ Severely Limited

Member's current place of residence: ____ Home/apartment ____ SNF/TCU ____ Assisted Living ____ Other

1.	Respiratory labored at times?	**Yes**	**No**	4.	Poor endurance and/or weakness?	**Yes**	**No**
2.	Current pressure sores?	**Yes**	**No**	5.	Significant edema??	**Yes**	**No**
3.	Poor balance and or history or risk of falls?	**Yes**	**No**	6.	Obesity?	**Yes**	**No**

7.	Holds on to furniture / walls for mobility?	**Yes**	**No**
8.	Can the mobility limitation be sufficiently resolved by the prescription of a cane or walker?	**Yes**	**No**
9.	Mobility limitations significantly impair ability to participate in MRADLs?	**Yes**	**No**
10.	Will MAE compensate their limitations to participate in MRADLs?	**Yes**	**No**
11.	Is patient or caregiver capable & willing to operate / maneuver MAE, POV / scooter or power wheelchair safely and participate in MRADLs**?**	**Yes**	**No**
12.	Does patient have sufficient upper extremity function to safely propel a manual wheelchair to participate in MRADLs?	**Yes**	**No**
13.	Does your patient need the additional features (i.e. optimal maneuverability, upgradeable / adaptable seating, etc.) of a power wheelchair to participate in MRADLs**?**	**Yes**	**No**

The information is a true and accurate representation of my patient's current condition. I hereby incorporate this document into my patient's medical record. This document is supported by additional medical records in my patient's file.

Physician or Treating Practitioner Signature:_____**Date:**_____