PediaCare MEDICAL
FOR OUR FUTURE

Order for Power Mobility Device

Serial #:	Practice Name:	Practice ID #:

PATIENT INFORMATION

First Name:	M.I.:	Last Name:	Date of Birth:	❑ M ❑ F
Address:				
City:	State:	Zip Code:	Telephone:	

GUARANTOR INFORMATION

First Name:	M.I.:	Last Name:	Relationship:	Date of Birth:	❑ M ❑ F
Primary Insurance:		Member ID#:		Group ID:	
Secondary Insurance:		Member ID#:		Group ID:	

Please fax a copy of front and back of insurance cards

Current Symptoms, Related Diagnosis, and History (Must be completed by physician or treating practitioner)

1. What medical conditions/diseases limit your patient's mobility in their home?

❑ CHF	❑ Diabetes/Neuropathy	❑ Muscular Dystrophy	❑ Renal Failure
❑ COPD	❑ Hemiparesis	❑ Osteoarthritis	❑ Rheumatoid Arthritis
❑ CVA	❑ Hemiplegia	❑ Paraparesis Paraplegia	❑ Other (please describe):
❑ Degenerative Joint Disease	❑ Multiple Sclerosis	❑ Parkinson's Disease	_____

2. Symptoms

❑ Abnormal Gait	❑ Fatigue	❑ Paralysis	❑ Vertigo
❑ Amputation	❑ Intermittent Claudication	❑ Shortness of Breath	❑ Walking Limitations
❑ Cardiac Arrhythmias	❑ Muscular Dystrophy	❑ Syncope	❑ Weakness
❑ Chest Pain	❑ Orthostasis	❑ Tremor	❑ Other (please describe):
			_____

3. Pain Location

❑ Head	❑ Pelvis/Groin	❑ R/L Arm	❑ R/L Ankle/Foot
❑ Face	❑ Upper Back	❑ R/L Elbow	❑ Other (please describe):
❑ Neck	❑ Lower Back	❑ R/L Wrist/Hand	_____
❑ Chest	❑ Sacrum	❑ R/L Hip/Thigh	
❑ Abdomen	❑ R/L Shoulder	❑ R/L Knee	

Physical Exam (Must be completed by physician or treating practitioner)

Ht:	Wt:	B/P:	Pulse (resting):	Pulse (exertion):

Shortness of Breath at Rest? ❑ Y / ❑ N	Current Pressure Sores? ❑ Y / ❑ N	Able to Shift Weight? ❑ Y / ❑ N
Shortness of Breath w/Exertion? ❑ Y/❑ N	History of Pressure Sores? ❑ Y / ❑ N	Poor Balance? ❑ Y / ❑ N
Is O2 Required? ❑ Y / ❑ N	Locations? _____	Poor Endurance? ❑ Y / ❑ N
Number of Liters? _____	Stage? _____	History of Falls? ❑ Y / ❑ N
O2 Sats? _____	Significant Edema? ❑ Y / ❑ N	Risk of Falls? ❑ Y / ❑ N

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Medications (List all medications the patient is currently taking relating to the need of a power mobility device)		
Medication	Date Started	Dosage

History of Present Problem

1. Functional Ambulatory Limitations (Complete all limitations that apply)

Gait/Walk Pattern ❑ Normal ❑ Ataxic ❑ Shuffling ❑ Mod. Assist ❑ Max. Assist ❑ Non-Ambulatory

Limitation	Onset	Description	Diagnosis
Balance/History or Risk of Falls			
Fatigue/Weakness			
Inability to Ambulate			
Other: _____			

2. Physical Limitations (Check all limitations that apply and describe all non-normal findings)

Upper Body Weakness	❑ Mild	❑ Moderate (Describe) _____	❑ Severe (Describe) _____
Upper Body Pain	❑ Mild	❑ Moderate (Describe) _____	❑ Severe (Describe) _____
Upper Body Range of Motion	❑ Normal	❑ Partially Limited (Describe) _____	❑ Severely Limited (Describe) _____
Lower Body Weakness	❑ Mild	❑ Moderate (Describe) _____	❑ Severe (Describe) _____
Lower Body Pain	❑ Mild	❑ Moderate (Describe) _____	❑ Severe (Describe) _____
Lower Body Range of Motion	❑ Normal	❑ Partially Limited (Describe) _____	❑ Severely Limited (Describe) _____

Ambulatory Status in Relation to Mobility Related Activities of Daily Living (MRADL) in Home

1. Without a mobility aid, how far can the patient safely walk without stopping? _____ ft.
   Does this distance allow the patient to independently accomplish ALL MRADL in the home in a safe and timely fashion?
   ❑ Yes ❑ No If No, please describe: _____
   (e.g., required significant rest, risk of falling, can only do once per day, etc.)
2. Please select all MRADL that your patient is unable to accomplish in the home in a safe and timely fashion due to mobility limitations.
   ❑ Feeding ❑ Bathing ❑ Grooming ❑ Dressing ❑ Toileting ❑ Other: _____
3. Does the patient have the ability to stand from a seated position without assistance?
   ❑ Yes ❑ No If No, please describe transferring options the patient could use: _____

Mobility Determination Questions

1. Can a cane or walker meet this patient's mobility needs to independently accomplish ALL mobility related activities of daily living (MRADL) in the home in a safe and timely fashion?
   ❑ Yes ❑ No If No, describe the condition and/or diagnosis related to the safe and timely completion of their MRADL:
   _____
   _____
2. Can a manual wheelchair meet this patient's mobility needs to independently accomplish ALL MRADL in the home in a safe and timely fashion?
   ❑ Yes ❑ No If No, describe the condition and/or diagnosis related to the safe and timely completion of their MRADL:
   _____
   _____

Mobility Determination Questions (cont'd)

3. How has your patient's condition/functional limitations changed so that they now require a power mobility device to complete their MRADL inside the home?

_____

_____

4. In order to qualify for a power wheelchair, you must consider and rule out a power operated vehicle/scooter. Some of the limitations of the power operated vehicle/scooter or reasons a patient would not be able to use a power operated vehicle/scooter are listed below. Check all applicable limitations or conditions.

● Patient requires elevating leg rest (ELR) Examples of limitations/conditions include: ❑ Patient has a musculoskeletal condition or presence of cast or brace which prevents 90 degree flexion at knee ❑ Patient has significant edema of lower extremities that requires having an elevated leg rest ❑ Patient meets criteria for and has reclining back on wheelchair	● Patient requires fully reclining back seat Examples of limitations/conditions include: ❑ Patient has a risk for development of a pressure ulcer and is unable to perform a functional weight shift ❑ Patient utilizes intermittent catheterization for bladder management and is unable to independently transfer from the wheelchair to the bed
● Patient requires adjustable height armrests Examples of limitations/conditions include: ❑ Patient requires an arm height that is different than that available using nonadjustable arms ❑ Patient spends at least 2 hours per day in the wheelchair	❑ Patient's home presents insufficient space for maneuvering power operated vehicle/scooter ❑ Patient is unable to safely operate power operated vehicle/scooter ❑ Patient presents poor trunk stability
❑ Patient needs special seat cushion for skin protection ❑ Other: _____	❑ Patient requires joystick controller Patient cannot operate handlebar controller

❑ None of the above limitations apply. Therefore the patient may not qualify for a power wheelchair, however the patient may qualify for a power operated vehicle/scooter.

5. Does the patient have the physical and mental abilities to safely operate a power mobility device in their home?
❑ Yes ❑ No If No, describe why: _____

_____

6. Is your patient willing and motivated to use power mobility equipment in their home?
❑ Yes ❑ No If No, describe what findings support that the patient is not motivated to operate a power mobility device in the home: _____

_____

❑ Based on this face-to-face evaluation, the patient has functional limitations that support the need for a **standard power mobility device** and does not require further evaluation.

❑ Based on this face-to-face evaluation, the patient has functional limitations that support the need for a **complex rehabilitation power mobility device** but a specialty evaluation is required. (A specialty Seating/Mobility Evaluation will be scheduled and a follow-up assessment completed within the next 45 days.)

❑ Based on this face-to-face evaluation, the patient **does not** have functional limitations that support the need for a power mobility device and does not require further evaluation.

Beneficiary's Name:	Date of Face-to-Face Examination:	Length of Need:

Description of item that is ordered. This may be general - e.g."power wheelchair"- or may be detailed:

_____

Pertinent diagnosis/conditions that relate to the need for the Power Mobility Device (PMD):

_____

TERMS AND CONDITIONS

I, the undersigned, certify that the above prescribed equipment and supplies ore reasonable and necessary according to acceptable medical standards in the treatment of this condition. I confirm that this patient meets the criteria for coverage as indicated above.

Physician Name (Printed):	Physician NPI:
Physician Signature (no stamps):	Date:

RELEASE OF LIABILITY

I hereby release my physician of any liability relating to the purchase or rental of this equipment. I understand that this equipment is the property of PCM.

SUPPLIER STANDARDS FOR MEDICARE ONLY

A supplier must be in compliance with all applicable Federal and State licensure and regulatory requirements and cannot contract with an individual or entity to provide licensed services.
A supplier must provide complete and accurate information on the DMEPOS supplier application. Any changes to this information must be reported to the National Supplier Clearinghouse within 30 days.
An authorized individual (one whose signature is binding) must sign the application for billing privileges.
A supplier must fill orders from its own inventory, or must contract with other companies for the purchase of items necessary to fill the order. A supplier may not contract with any entity that is currently excluded from the Medicare program, any State health care programs, or from any other Federal procurement or non-procurement programs.
A supplier must advise beneficiaries that they may rent or purchase inexpensive or routinely purchased durable medical equipment, and of the purchase option for capped rental equipment.
A supplier must notify beneficiaries of warranty coverage and honor all warranties under applicable State law, and repair or replace free of charge Medicare covered items that are under warranty.
A supplier must maintain a physical facility on an appropriate site. This standard requires that the location is accessible to the public and staffed during posted hours of business. The location must be at least 200 square feet and contain space for storing records.
A supplier must permit PCM, or its agents to conduct on-site inspections to ascertain the supplier's compliance with these standards. The supplier location must be accessible to beneficiaries during reasonable business hours, and must maintain a visible sign and posted hours of operation.
A supplier must maintain a primary business telephone listed under the name of the business in a local directory or a toll free number available through directory assistance. The exclusive use of a beeper, answering machine, answering service or cell phone during posted business hours is prohibited.
A supplier must have comprehensive liability insurance in the amount of at least $300,000 that covers both the supplier's place of business and all customers and employees of the supplier. If the supplier manufactures its own items, this insurance must also cover product liability and completed operations.
A supplier must agree not to initiate telephone contact with beneficiaries, with a few exceptions allowed. This standard prohibits suppliers from contacting a Medicare beneficiary based on a physician's oral order unless an exception applies.
A supplier is responsible for delivery and must instruct beneficiaries on use of Medicare covered items, and maintain proof of delivery.
A supplier must answer questions and respond to complaints of beneficiaries, and maintain documentation of such contacts.
A supplier must maintain and replace at no charge or repair directly, or through a service contract with another company, Medicare-covered items it has rented to beneficiaries.
A supplier must accept returns of substandard (less than full quality for the particular item) or unsuitable items (inappropriate for the beneficiary at the time it was fitted and rented or sold) from beneficiaries.
A supplier must disclose these supplier standards to each beneficiary to whom it supplies a Medicare-covered item.
A supplier must disclose to the government any person having ownership, financial, or control interest in the supplier.
A supplier must not convey or reassign a supplier number; i.e., the supplier may not sell or allow another entity to use its Medicare billing number.
A supplier must have a complaint resolution protocol established to address beneficiary complaints that relate to these standards. A record of these complaints must be maintained at the physical facility.
Complaint records must include: the name, address, telephone number and health insurance claim number of the beneficiary, a summary of the complaint, and any actions taken to resolve it.
A supplier must agree to furnish PCM any information required by the Medicare statute and implementing regulations.
All suppliers must be accredited by a PCM-approved accreditation organization in order to receive and retain a supplier billing number. The accreditation must indicate the specific products and services, for which the supplier is accredited in order for the supplier to receive payment of those specific products and services (except for certain exempt pharmaceuticals). Implementation Date - October 1, 2009.
All suppliers must notify their accreditation organization when a new DMEPOS location is opened.
All supplier locations, whether owned or subcontracted, must meet the DMEPOS quality standards and be separately accredited in order to bill Medicare.
All suppliers must disclose upon enrollment all products and services, including the addition of new product lines for which they are seeking accreditation.
Must meet the surety bond requirements specified in 42 C.F.R. 424.57(c). Implementation date- May 4, 2009
A supplier must obtain oxygen from a state-licensed oxygen supplier.
A supplier must maintain ordering and referring documentation consistent with provisions found in 42 C.F.R. 424.516(f).
DMEPOS suppliers are prohibited from sharing a practice location with certain other Medicare providers and suppliers.
DMEPOS suppliers must remain open to the public for a minimum of 30 hours per week with certain exceptions.

AUTHORIZATION FOR RELEASE OF MEDICAL AND OTHER INFORMATION

I understand that by signing below I authorize PCM to request, obtain, and use my medical or other information as required to verify medical necessity and process my order for products or equipment, determine my eligibility, coverage and benefits, submit claims for payment and/or respond to insurers' inquiries. I authorize PCM to discuss assignment of Medicare, Medicaid, Medicare Supplemental or other insurance benefits for products, services, and/or equipment furnished to me by PCM.

ASSIGNMENT OF BENEFITS

The undersigned, as or on behalf of Patient, hereby request that payment of authorized benefits be made to PCM and authorizes PCM to collect directly all public and private insurance coverage benefits due for any equipment/supplies/services furnished to Patient by PCM. In the event benefits payments due PCM are paid directly to patient or the undersigned, the payee will immediately and without request from PCM, endorse and remit to PCM all such benefit payment checks. On assigned Medicare claims, PCM agrees to accept the applicable Medicare allowable amount as payment in full for covered equipment/supplies/services.

AGREEMENT TO PAY

The undersigned agrees to pay for all equipment/supplies/services provided by PCM to Patient. I understand my insurance company will be billed for the nebulizer and accessories not to exceed $285.00 and for any medications dispensed. The balance due will be that portion of PCM charges not paid by insurance or any other payer and will include co-pay, coinsurance and/or deductible amounts, as well as amounts due for non-covered equipment/services/supplies rendered to the Patient, by PCM. The undersigned agrees to accept financial responsibility and pay the balance due in full upon receipt of an invoice from PCM. If payment is not made, PCM will pursue its normal collection policy.

PATIENT BILL OF RIGHTS

You have the right to:

- Be treated with dignity and respect without regard to race, color, creed, sex, age, national, or ethnic origin, diagnosis, or source of payment.
- Be provided with information regarding available services and charges.
- Be informed about his/her illness and treatment, when and how services will be provided, the name and function of any person and agency providing care and service, and the name of any person responsible for coordination of care.
- Make informal decisions about his/her care and actively participate in the planning of care
- Be instructed in his/her care therapy in order to reach the highest level of self care and wellness.
- Receive prompt response to all reasonable interruption of service.
- Continuity of care and service provided by personnel who are qualified through education and experience to perform the service for which they are responsible
- Refuse treatment, within the confines of the law, after being fully informed of and understanding the consequences of such action.
- Confidentially and privacy in treatment and care, including confidential treatment of patient records, and to refuse their release to any individual outside, except in the case of transfer to another health facility, or as required by law or third-party contract.
- Voice complaint and grievance and be informed of procedure for registering complaints without reprisal, coercion, discrimination on or unreasonable interruption of services.

RESPONSIBILITIES OF THE PATIENT

The patient is responsible:

- For providing accurate and complete information regarding his/her medical history.
- For communication whether he/she clearly understands the course of treatment and plan of care.
- For following the plan of care and clinical condition.
- For reporting problems, unexpected changes in physical condition, re-hospitalizations, concerns or complaints.
- For accepting responsibility for his/her actions if refusing treatment.
- For fulfilling financial obligations for services.
- For respecting the rights of home caregivers.

This Agreement is used in lieu of the Patient's or his/her representative's signature on the "Request for Payment" HCFA-1500 and on other health insurance claim form requiring signature and thus, is an extension of those forms. Any person who misrepresents or falsifies information in making a Medicare claim may, upon conviction be subjected to fines and imprisonment under Federal Law. Penalties may also result from falsification or misrepresentation of other health insurance claims. A copy of this Agreement may be used in place of the original. I have received and have seen a demonstration of the following prescribed equipment by the ordering physician and I understand how to use/clean the equipment and applicable maintenance and warranty. The undersigned certifies that (1) he/she is the Patient or is duly authorized to execute this Patient Agreement and accept its terms on behalf of Patient; (2) that the information provided to PCM by or on behalf of Patient is correct; and (3) he/she has read the reverse side of this agreement in its entirety.