

## Mobility Assessment and Prior Authorization (PA) Request For Mobility Devices, Wheelchair Accessories and Seating Systems

Upload this request through the Provider Web Portal.

Questions? Call: (800) 525-2395

**Before completing this form, refer to the detailed instructions (FA-1B-I).****\*\*Completion of this form does not guarantee approval or reimbursement for the items requested.\*\*****NOTES:****SECTION I: PRIOR AUTHORIZATION (PA) INFORMATION***(This section to be completed by the Medicaid provider requesting PA.)*

1. PA Request Date:	2. Assessment Date:	3. Prescription/Order Date:
4. Request Type: <input type="checkbox"/> Initial <input type="checkbox"/> Continued Services <input type="checkbox"/> Retrospective <input type="checkbox"/> Unscheduled Revision		
5. For "retrospective" requests only, enter the Medicaid Eligibility Determination Date:		
6. For children under age 21 only, is this request a result of, or pursuant to Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Healthy Kids services? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		

**RECIPIENT INFORMATION** *(Recipient name must match Medicaid card/records.)*

7. Name <i>(last, first)</i> :	8. Recipient ID:
9a. Date of Birth:	9b. Age: ____ years ____ months
10. Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	
11. Phone:	
12. Address <i>(include city, state and zip)</i> :	
13. Recipient's place of residency <input type="checkbox"/> Hospital <input type="checkbox"/> Nursing Facility <input type="checkbox"/> ICF / MR <input type="checkbox"/> Group Home <input type="checkbox"/> Assisted Living <input type="checkbox"/> Private Home <input type="checkbox"/> Apartment <input type="checkbox"/> Temporary Lodging <input type="checkbox"/> Other <i>(specify)</i> : _____ Length of Residency: _____	
14. For recipients in or being discharged from a medical facility, enter actual or anticipated discharge date:	
15a. <i>Check all that apply and provide identification numbers as applicable:</i> The recipient is covered by: <input type="checkbox"/> Medicare Part A <input type="checkbox"/> Medicare Part B Medicare Number: _____ <input type="checkbox"/> Other Insurance Name <i>(if applicable)</i> : _____ Group ID Number: _____	
15b. Does this recipient meet the standard Medicare criteria for the requested item(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable <i>(If "No", PA will be processed. The provider agrees to obtain a signed Advance Beneficiary Notice (ABN) for any services Medicare does not cover due to medical necessity.)</i>	

**ORDERING PHYSICIAN/PRACTITIONER INFORMATION** *(Must be treating physician)*

16. Name:	17. NPI:
18. Address <i>(include city, state and zip)</i> :	
19. Phone:	20. Fax:
21. Contact Name:	

**SERVICING DME PROVIDER / SUPPLIER INFORMATION***(This section may be completed by any Medicaid provider involved in this request.)*

22. Name:	23. NPI:
24. Address <i>(include city, state and zip)</i> :	
25. Phone:	26. Fax:
27. Contact Name:	

## Mobility Assessment and Prior Authorization (PA) Request

**SECTION II: CURRENT EQUIPMENT / DEVICES**  
*(This section must be completed by the Medicaid provider requesting PA.)*

1. Identify equipment recipient currently has / uses relevant to this request. *(Check all that apply.)*  
 Manual Wheelchair     Power Wheelchair     Scooter / POV     Power Assist or Other Mobility Device  
 Mobility Base     Seating and Positioning Device(s)     Cane     Crutches  
 Walker     Geri Chair     Other: \_\_\_\_\_

2. Make: \_\_\_\_\_ Model: \_\_\_\_\_ Serial #: \_\_\_\_\_  
 Age of Equipment: \_\_\_\_\_ Within Manufacturer's Warranty?  Yes  No

3. If requesting a replacement device issued less than five years ago, check the appropriate box and explain below.  
 N / A     Growth     Change in Condition     Weight gain \_\_\_\_\_lbs.     Weight loss \_\_\_\_\_lbs.     Other  
 Explain: \_\_\_\_\_

4. Which specific MRADLs is the recipient unable to adequately complete using their current mobility devices and why?  
 \_\_\_\_\_

5. Can the current equipment be modified to accommodate the recipient's needs?  Yes  No  
 If yes, describe: \_\_\_\_\_

6. Has this equipment already been modified to accommodate the recipient's needs?  Yes  No  
 If yes, describe: \_\_\_\_\_

**EQUIPMENT/DEVICE(S) REQUESTED**

7. Identify the requested equipment / device(s). *(Check all that apply.)*  
 New Mobility Device     Manual Wheelchair     Power Wheelchair     Power Operated Vehicle / Scooter  
 Wheelchair Accessory     Seating and Positioning Items     Growth of Current Device  
 Replacement Mobility Device     Modification or Changes     Other Equipment  
 Enter a brief description and product code for each piece of equipment being requested. Submit an unaltered complete order form specific to the manufacturer and the model of the items being requested here.  
 \_\_\_\_\_

8. Is this request for a pediatric device?  Yes  No If no, skip the rest of this item.  
 Can this equipment be enlarged or reduced in size, width and depth?  Yes  No  N / A  
 Enter Available Seat Width Range *(if applicable)*: \_\_\_\_\_  
 Enter Available Seat Depth Range *(if applicable)*: \_\_\_\_\_  
 If this request is for a pediatric device, describe any additional growth capabilities associated with this equipment:  
 \_\_\_\_\_

## Mobility Assessment and Prior Authorization (PA) Request

9. List the name, credentials and professional license number of the person who completed Section II.

### SECTION III: CLINICAL ASSESSMENT

*(This section must be completed by the ordering physician / practitioner.)*

1. List pertinent diagnosis and describe conditions, symptoms or medical complaints that contributed to this request:  
*(Attach additional sheets if additional space is needed.)*

## Mobility Assessment and Prior Authorization (PA) Request

2. If primary medical condition preventing functional ambulation is related to conditions such as Congestive Heart Failure (CHF) or Chronic Obstructive Pulmonary Disease (COPD), 1) attach the progress notes from the last six office visits with the prescribing physician and 2) attach all pertinent documentation of severity of illness, which may include diagnostic tests such as, but not limited to:
- a. Echocardiogram report
  - b. Cardiolyte report
  - c. Cardiac catheterization report
  - d. Pulmonary function test
  - e. ABG's and/or O2 saturation on current oxygen flow rate

## Mobility Assessment and Prior Authorization (PA) Request

3. If primary medical condition preventing functional ambulation is related to conditions such as Degenerative Joint Disease, Degenerative Disc Disease or Spinal Stenosis, 1) attach all imaging reports documenting severity of illness, 2) attach the progress notes from the last six office visits with the prescribing physician 3) describe all failed conservative treatments and include assessments, documentation and/or progress notes from those entities and 4) provide dates of each set of treatments. Treatments may include but are not limited to:
- a. PT/OT
  - b. Pain management
  - c. NSAIDS
  - d. Bracing and injections
  - e. Surgical treatments

## Mobility Assessment and Prior Authorization (PA) Request

4. Diagnosis code(s):	
5. Describe any recent or anticipated changes in the recipient's medical, physical, mental and/or functional status:	
6. Describe cognitive and/or developmental deficits:	
7. Does the recipient have any hearing and / or vision deficits that should be considered? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is the deficit compensated by corrective devices? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe the recipient's compliance with use of the corrective devices:	
8. Describe the recipient's ability to effectively communicate their needs and comfort level:	
9. Does the recipient have any sensory or motor developmental delays/deficits? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe the recipient's abilities and limitations:	
10. Describe <i>age-appropriate</i> bowel and bladder continence/incontinence ( <i>include toilet training, frequency of incontinent episodes, interventions, need for self catheterizations, indwelling catheters, etc.</i> ):	
11. Describe skin integrity, sensation, existing wounds and include current history of pressure ulcers ( <i>include number, size and location</i> ):	
12. Describe current or recent wound care plan for ongoing treatment ( <i>if applicable</i> ):	
13. Recipient's <i>Actual</i> Height:	14. Recipient's <i>Actual</i> Weight:
15. Describe how the ordered/prescribed item(s) will enable the recipient to perform MRADLs that cannot be completed with current equipment. Which specific MRADLs will the recipient be able to complete with use of the requested equipment?	
16. Length of need for requested device(s):	
17. Who will <i>operate</i> the equipment being requested? <input type="checkbox"/> Recipient <input type="checkbox"/> Caregiver <input type="checkbox"/> Both If both, explain:	
18. List the name, credentials and professional license number of the prescribing practitioner who completed Section III.	

## Mobility Assessment and Prior Authorization (PA) Request

### SECTION IV: PHYSICAL ASSESSMENT

*(This section must be completed by the ordering physician/practitioner, PT, OT or a seating specialist not associated with the DME provider/supplier. If a standardized assessment form was used, please indicate which one. Current information (within past 6 months) may be copied into this document. If attaching/submitted additional supportive documentation, please indicate the corresponding number of the question(s) the information responds to.)*

1. Complete the following table to describe postural control and functional abilities.

Postural Control	Good	Fair	Poor	None	Indicate presence of pain, scoliosis, obliquity, rotation, tone, contractures, spasticity, deformity, absence of extremity, etc.
Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Arms (UEs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Trunk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Back/Spine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Legs (LEs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ankles/Feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Functional Ability	Good	Fair	Poor	None	List limitations if applicable, e.g., manual muscle test, grip strength, limits in ROM and functional use.
Upper extremities (L)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
(R)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hands (L)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
(R)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lower extremities (L)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
(R)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

2. Describe dexterity (fine and gross motor skill) issues related to the types of devices being requested:

3. Describe extremity tone, strength, spasticity, coordination and range of motion:

4. Describe sitting posture and balance (*head and shoulder/scapula position, pelvic tilt, obliquities, leg position, rotation, etc.*):

5. Describe contractures / scoliosis / kyphosis / lordosis:

## Mobility Assessment and Prior Authorization (PA) Request

6. Describe mobility-related endurance status (e.g., functional propulsion speed and distance, amount of exertion):

7. Describe weight shift or repositioning ability:

8. Check the appropriate box to describe the recipient's ability to perform each activity:

Stand:  Independent  Limited assistance  Extensive assistance  Fully dependent

Transfer:  Independent  Limited assistance  Extensive assistance  Fully dependent

Pivot:  Independent  Limited assistance  Extensive assistance  Fully dependent

Bear Weight:  Independent  Limited assistance  Extensive assistance  Fully dependent

9. Describe ambulation ability (include distance, stability, endurance, respiratory/cardiac status):

10. Describe how deficits are currently managed or compensated:

11. Is the recipient O2 dependent?  Yes  No If yes, enter LPM: \_\_\_\_\_

Gas cylinders / tanks  Portable (shoulder bag) system  Portable liquid system

12. Is the recipient ventilator dependent?  Yes  No

13. Indicate if there are any attachments to further support the above clinical information:

PT report or letter  OT report or letter  Physician / Practitioner notes, report(s) or letter  Other

14. List the name, credentials and professional license number of the person who completed Section IV.

### SECTION V. MOBILITY RELATED ACTIVITIES OF DAILY LIVING (MRADLs)

(This section must be completed by the ordering physician/practitioner, PT, OT or a seating specialist who is not associated with the DME provider/supplier.)

1. Describe the recipient's current, usual daily routine:

2. Describe the recipient's current living situation; include who lives with the recipient and who provides assistance/care.

3. Does the recipient receive supportive services? If so, which services and include frequency?



## Mobility Assessment and Prior Authorization (PA) Request

4. Complete the following table to indicate the recipient's abilities to perform MRADLs: Independent = self performs, Limited Assist = does most with set up/cueing, Extensive Assist = limited performance with hands-on assist/support, Unable = full/total assist of others

MRADL	Inde- pendent	Limited Assist	Extensive Assist	Unable	Comments and Assistive Devices
Continen- ce: Bowel Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Continen- ce devices used: <input type="checkbox"/> None <input type="checkbox"/> Catheter (indwelling) <input type="checkbox"/> Catheter (intermittent) <input type="checkbox"/> Ostomy <input type="checkbox"/> Diapers <input type="checkbox"/> Other
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Grooming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

### Transfers

Bed to Chair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Devices Used:
Chair to Bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Devices Used:
Toilet (on/off)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Devices Used:
Home to Community	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Devices Used:

5. List any other MRADL considerations (if applicable):

6. Did a DME provider/supplier complete or assist with completion of this section?  Yes  No

7. List the name, credentials and professional license number of the person who completed Section V.

### SECTION VI: SEATING AND POSITIONING CONSIDERATIONS FOR ANY TYPE OF WHEELCHAIR

(This section may be completed by a DME provider/supplier, an ordering physician/practitioner, a PT, an OT or a seating specialist; note special instructions for Fields 2a-2j.)

1.  This request is not for a seating system(s). **(Skip to Section VII.)**

2. Provide the recipient's measurements in inches. Items 2a-2j, must be completed by the DME provider/supplier.

2a. Hip Width:	2b. Upper Leg Length:	2c. Lower Leg Length:
2d. Seat to Elbow:	2e. Seat to Scapula:	2f. Seat to Shoulder:
2g. Seat to Occipital:	2h. Seat to Top of Head:	2i. Chest Width:

2j. Other:

3. Provide the requested measurements in inches to describe the size/specifications of the equipment / device.

3a. Seat Width:	3b. Seat Depth:	3c. Seat to Footrest:
3d. Seat to Floor Height:	3e. Seat to Armrest:	3f. Back Height:
3g. Equip. Overall Width:	3h. Turn Radius:	3i. Weight Capacity:

## Mobility Assessment and Prior Authorization (PA) Request

### 4. Requested Seat System Components

(Check all that apply. Attach a medical assessment that includes each checked component.)

- Tilt in Space   
  Reclining Back   
  ELR / AFP   
  Seat Elevated  
 Solid Seat   
  Solid Back   
  Cushion   
  Back   
  Headrest With Adjustable Mounting Hardware  
 S/A Lateral Trunk Supports   
  Positioning Chest Harness   
  Velcro Chest Belt   
  Arm Troughs  
 Positioning Lap Belt   
  Lateral Hip Supports   
  Knee Adductors   
  Foot Positioners  
 Flip-Down Abductor   
  Upper Extremity Support Tray

4a. Explain the deficit(s) that each component will ameliorate or correct.

5. List any other seat system or chair components, e.g., joystick midline mount, alternative drive control:

5a. Explain the deficit(s) that each will ameliorate or correct.

### WHEELCHAIR ACCESSORIES

6. List any wheelchair accessories being requested: (include the unaltered complete order form for all accessories/parts specific to the manufacturer and the model of the items being requested)

6a. Explain the deficit(s) that each accessory will ameliorate or correct.

7. Describe features of the requested equipment that allow for modified dimensions/growth accommodations. Can this equipment be enlarged or reduced in size? (Requests for pediatric recipients *must* address growth capabilities.)

8. Did a DME provider/supplier complete or assist with completion of this section?     Yes     No

9. List the name, credentials and professional license number of the person who completed Section VI.

## Mobility Assessment and Prior Authorization (PA) Request

### SECTION VII: ENVIRONMENTAL ASSESSMENT

*(This section must be completed by the servicing DME provider/supplier.)*

1. Describe the recipient's living space in general terms:

2. Describe home residence accessibility and include mapping of rooms, stairs, turning radius, ramps, maneuvering space, access into/out of the home and between rooms, etc. Attach a separate document if necessary.

3. Width of Doorways (please enter measurements in inches):

Entrance: \_\_\_\_\_ Bedroom: \_\_\_\_\_ Bathroom: \_\_\_\_\_ Kitchen: \_\_\_\_\_

Hallway: \_\_\_\_\_ Other: \_\_\_\_\_

4. Describe floor covering throughout the home:

5. Can this equipment be used inside the home to perform MRADLs?  Yes  No If no, explain:

6. Has the requested equipment been evaluated in this environment?  Yes  No If no, explain:

7. Will the recipient be transported in the requested device/equipment?  Yes  No

8. Describe potential accessibility issues in other settings where the recipient may routinely use this equipment, e.g., accessing transportation, work, school, other:

9. List the name, credentials and professional license number of the person who completed Section VII.



## Mobility Assessment and Prior Authorization (PA) Request

**THE FOLLOWING ITEMS MUST BE ATTACHED TO/SUBMITTED WITH THIS FORM:** (1) a medical order or prescription signed by the physician/practitioner; (2) any additional documentation that supports medical necessity, including but not limited to specific medical records as required throughout this assessment and documentation of the environmental assessment; (3) the unaltered complete order form specific to the manufacturer and the model of the items being requested; and (4) a copy of the equipment manufacturer's invoice for all appropriate items, codes without pricing, or when requested by Nevada Medicaid and Check Up. Failure of the provider/supplier to submit the required documentation may result in denial.

### SECTION IX: ATTESTATION STATEMENTS AND SIGNATURES

*This section must be completed by all entities that completed portions of this form. The entities signing this section, whether done pen-to-paper or electronically (signature stamps are not permitted), are attesting that they have no financial, administrative or contractual relationship with, and receive no form of compensation from the billing DME provider/supplier, or that the DME provider/supplier receives no form of compensation from the other entities. Failure to disclose or knowingly providing incorrect information is considered fraud and will be treated as such.*

#### 1. DME Provider/Supplier:

*I acknowledge that the assessor, PT, OT or ordering physician/practitioner may have no financial relationship with the DME provider/supplier. The Mobility Assessment portions of this form and written supportive documentation were provided by an individual who is fiscally, administratively and contractually independent from the DME provider/supplier and who receives no form of compensation from the billing DME provider/supplier. I certify that the equipment requested and to be provided if approval is granted, is appropriate for the recipient and the recipient's residence.*

**DME Provider/Supplier's Signature:**

**Date:**

**Printed name and title:**

#### 2. Assessor (PT, OT, Ordering Physician/Practitioner, non-DME provider Wheelchair Seating Specialist):

*I acknowledge the assessor, PT, OT, ordering physician/practitioner may have no financial relationship with the DME provider/supplier. The Mobility Assessment portions of this form and written supportive documentation were provided by an individual who is fiscally, administratively and contractually independent from the DME provider/supplier and who receives no form of compensation from the billing DME provider/supplier.*

**PT, OT, or other Seating Specialist's Signature:**

**Date:**

**Printed name and title:**

**PT, OT, or other Seating Specialist's Signature:**

**Date:**

**Printed name and title:**

#### 3. Ordering/Prescribing Physician/Practitioner: (Must be the same as indicated on page 1.)

- I acknowledge the assessor, PT, OT, ordering physician/practitioner may have no financial relationship with the DME provider/supplier. The Mobility Assessment portions of this form and written supportive documentation must be performed by an individual who is fiscally, administratively, and contractually independent from the DME provider/supplier and who receives no form of compensation from the billing DME provider/supplier.*
- I have prescribed the items listed in Section VIII, "Prior Authorization (PA) Summary."
- I have assessed this recipient face-to-face and have **(check one or both)**  **completed and/or**  **received and reviewed** in its entirety this 13 page Mobility Assessment and Prior Authorization Request and any additional documentation indicated as an attachment. I concur with the findings and agree the requested items (as summarized in Section VIII above) are medically necessary and consistent with the plan of care for this recipient.

**Ordering/Prescribing Physician/Practitioner's Signature:**

**Date:**

**Printed name and title:**

*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.*