Medical Management & Policy
Fax Number: 412-544-2921

Certificate of Medical Necessity (CMN) for Power Operated Vehicle

Date: _____/_____/_____   Requesting Provider: _____

Pt. Name: _____   I.D. Number: _____

1. Does the patient have a mobility limitation that prevents, significantly impairs, or substantially delays his/her ability to participate in one or more mobility-related activities of daily living such as toileting, feeding, dressing, grooming, and bathing in customary locations within the home?	Y	N
2. What is (are) the diagnosis(es) for which this mobility device is required?		
3. What other ambulatory aides has member tried and failed?		
4. Does the patient's home provide adequate access between rooms, maneuvering space, and floor surfaces for use of a power operated vehicle?	Y	N
If yes, is a written report of an on-site evaluation available?	Y	N
5. Have all type of manual wheelchairs (including lightweights) been considered and ruled out?	Y	N
6. What is the reason that an optimally configured manual wheelchair is not acceptable?		
7. Does the patient require (or currently use) a POV to move around in their residence?	Y	N
8. Does the patient require a POV only for movement outside their residence?	Y	N
9. Is the patient able to safely transfer to and from a POV (strength and coordination)?		
10. Can the patient operate the tiller steering system (strength, coordination, judgment)?	Y	N
11. Are the patient's mental capabilities (e.g., cognition, judgment) and physical capabilities (e.g., vision) sufficient for safe mobility using a POV in the home?	Y	N
12. Can the patient maintain postural stability and position (without lateral support) while operating the POV in the home?	Y	N
13. What is the patient's body weight? (not to exceed requested POV capacity)		
14. Has the patient expressed any unwillingness to use this POV in the home?	Y	N

Additional Clinical Rationale (Please Print):

Medical Management & Policy
Fax Number: 412-544-2921

Certificate of Medical Necessity (CMN) for Customized Manual Wheelchair
Continued

Contact Name: _____   Phone :_____

_____   _____

Physician Signature (Stamps are not acceptable)   **Date**

Key - **(Y)**es, **(N)**o