FAX: 855-475-5614 PHONE: 833-523-2609

Prior Authorization POV Request Form

Date Requested: **Date of Service:**

☐ Standard Request	☐ Expedited Request I Certify that waiting for a decision under the standard time frame could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy. Provider signature Required: ______________________________ Date__________
Patient Name:	Ordering Provider:
Patient Health Plan ID #	Service Provider:
Patient birthdate:	Contact Name:
ICD 10 Diagnosis:	Contact Phone: Fax:
Height: ____ Feet _____ Inches Weight: ____ Lbs.	Certification Date: __/__/____ ☐Initial ☐Revised Face-to-Face visit date: ____/____/_____
A. 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 ☐NA
B. The beneficiary's mobility limitation cannot be sufficiently and safely resolved by the use of an appropriately fitted cane or walker.	☐Y ☐N ☐NA
C. The beneficiary does not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair in the home to perform MRADLs during a typical day. Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function. An optimally-configured manual wheelchair is one with an appropriate wheelbase, device weight, seating options, and other appropriate nonpowered accessories.	☐Y ☐N ☐NA
D. The beneficiary is able to: Safely transfer to and from a POV, AND Operate the tiller steering system, AND Maintain postural stability and position while operating the POV in the home	☐Y ☐N ☐NA
E. The beneficiary's mental capabilities (e.g., cognition, judgment) and physical capabilities (e.g., vision) are sufficient for safe mobility using a POV in the home.	☐Y ☐N ☐NA
F. The beneficiary's home provides adequate access between rooms, maneuvering space, and surfaces for the operation of the POV that is provided.	☐Y ☐N ☐NA
G. The beneficiary's weight is less than or equal to the weight capacity of the POV that is provided and greater than or equal to 95% of the weight capacity of the next lower weight class POV – i.e., a Heavy Duty POV is	☐Y ☐N ☐NA

covered for a beneficiary weighing 285 – 450 pounds; a Very Heavy Duty POV is covered for a beneficiary weighing 428 – 600 pounds.	
H. Use of a POV will significantly improve the beneficiary's ability to participate in MRADLs and the beneficiary will use it in the home. The beneficiary has not expressed an unwillingness to use a POV in the home.	☐Y ☐N ☐NA
I.) The beneficiary has not expressed an unwillingness to use a POV in the home.	☐Y ☐N

DME Equipment

Equipment	HCPCS	Quantity

Please fax/email completed form along with Supporting Clinical to include pertinent mobility/ADL issues, Balance and stability concerns, pertinent global health concerns and any special or unique considerations to 855-475-5614.
Approval is based on provider attestation that the patient is physically unable to manage the mobility requirements with a manual w/c, that UE and LE mobility restrictions are supported by medical record documentation, PMD is medically necessary, and that CMS guidelines for the medical necessity of the POV have been applied, periodically reviewed and are documented consistently.

Physician Signature: ________________________________ Date_____________