Utah Department of
Health & Human Services
Integrated Healthcare

Wheelchair Final Evaluation Form

Must be completed within 10 business days of delivery date
See Medical Supplies and Durable Medical Equipment Manual for criteria related to this form

Member's Name: _____

Member's Medicaid ID #: _____

Prior Authorization #(s) for Wheelchair: _____

VENDOR

The frame, accessories, attachments, components, and options are present upon delivery, as approved on the prior authorization? ☐ YES ☐ NO

_____	_____	_____
Vendor Name (print)	Vendor Signature	Today's Date

THERAPIST EVALUATION

Does the wheelchair fit the member properly? ☐ YES ☐ NO

Document the member/caregiver is appropriately trained on the proper use and function, and demonstrates the ability to safely and efficiently operate this wheelchair? ☐ YES ☐ NO

Therapist performing final evaluation:

_____	_____	_____
Therapist's Name (print)	Therapist's Signature	Today's Date

MEMBER'S STATEMENT*

The wheelchair that I received fits my needs. ☐ YES ☐ NO

The wheelchair is what I was told would be ordered. ☐ YES ☐ NO

The training was completed and I am comfortable operating the newly delivered wheelchair. ☐ YES ☐ NO

_____	_____	_____
Member's Name* (print)	Member's Signature*	Today's Date

*Caregiver when applicable

After completion of the final evaluation, include this form with the claim submission and fax to 801-536-0481.

Updated January 2020