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 Whee	elchair:			
VENDOR				
The frame, accessories, attachments, components, and options are present upon delivery, as approved on the prior authorization?			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?			NO	
Therapist performing final eval	uation:			
Therapist's Name (print)	Therapist's Signature	2	_	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.