ALABAMA MEDICAID AGENCY

Wheelchair Modification/Repair Form

PHI CONFIDENTIAL

Date: _____

Repairs and/or replacement of parts for custom/power wheelchairs that exceed $1000.00 per day and all requests for recipients under 21 require prior authorization. This form is intended to ensure needed information is submitted. If also submitting a Letter of Medical Necessity (LMN), please indicate, "See attached," on the repair form if the information is already documented in the LMN.

The following documentation is REQUIRED:

FOR REPAIRS OR REPLACEMENT WHEELCHAIR COMPONENTS EXCEEDING $1000 TO MAKE CHAIR OPERABLE:

1. A signed prescription / detailed written order from an MD, DO, or NP and PT/OT if applicable. A PT/OT evaluation is required if changing/growing seating, changing drive controls, adding a power function or power assist, etc.
2. Patient 1st/EPSDT Referral (if applicable)
3. Justification for replacement of wheelchair (non-seating) components signed by repair technician or provider ATP / SMS – by filling out the repair form

FOR REPLACEMENT OF SEATING AND POSITIONING COMPONENTS (I.E. BACK, CUSHION, ETC) EXCEEDING $1000 or if <$1000 and is a change in seating equipment due to change in condition (posture, skin breakdown, growth changes, etc.):

1. A signed prescription / detailed written order from an MD, DO, or NP
2. Patient 1st/EPSDT Referral (if applicable)
3. Justification for replacement seating & positioning components signed by a PT/OT.

Note: If the replacement cushion and/or backrest is simply a replacement and a physician or NP can send a note stating the patient has not had any medical/functional/postural/skin condition changes since receiving the current cushion and/or backrest, then a PT/OT evaluation is not required. If there has been a change in condition as in one of the previous situations a PT/OT evaluation will be required to ensure proper equipment is being recommended.

Recipient Name	Recipient #	PA Number

Reason for Modification/Repairs:

Diagnosis and additional comments:

Letter of Medical Necessity **(If needed)** submitted by: Physician ☐ Therapist ☐

Date of initial Medicaid Request: _____

Describe the condition of the chair:

How old is the current chair? (Please provide make/model and age of chair needing repairs)

Describe in detail any previous repairs to the current chair: (A print out of repair history is accepted)

Describe any current warranties and date of expiration:

Describe estimated cost of repair(s) or replacement part(s): (MSRP quotes should be provided)

Describe the cost to replace the current wheelchair, if applicable:

Indicate whether or not the current wheelchair has been evaluated for abuse or neglect; if applicable, submit the police/fire report.

Disclaimer: The Alabama Medicaid Agency or contracted designee reserves the right to request additional information as needed to support medical necessity of the modifications or repairs.

Please ensure applicable signatures are documented below.

_____	_____
Printed name of ATP/SMS	Printed name of PT/OT
_____	_____
Signature of ATP/SMS	Signature of PT/OT
_____	_____
Date	Date