Kansas Medical Assistance Program
PO Box 3571
Topeka, KS 66601-3571
Provider 1-800-933-6593

MANUAL WHEELCHAIR

PRIOR AUTHORIZATION REQUEST

THIS FORM MUST BE COMPLETED IN ITS ENTIRETY.

Provider #: _____ Provider NPI #: _____

Provider Name, Address & Phone #:

PA does not guarantee eligibility.

If service is not covered by KMAP, PA is void.

PA does not override Primary Care Network (PCN) referral limitation.

PA does not override program limitations.

GENERAL BENEFICIARY INFORMATION

Beneficiary Medicaid ID#	Beneficiary name (last, first, MI)	Date of birth

Diagnosis description

Date: _____ Ht: _____ Wt: _____ Is condition stable? Yes ☐ No ☐

Approved HCPC code must be used for all requests: _____

Manufacture name: _____ Model: _____

The following must be included with request:

☐ Manufacturer retail pricing including wheelchair options (or invoice if renting a used in-stock wheelchair)
☐ Warranty information
☐ Signed/dated prescription including medical necessity for any wheelchair options being requested

(1) Wheelchair is being requested for: ☐ Purchase ☐ Rental
(2) How long will the wheelchair be needed?_____
(3) Does the beneficiary need the wheelchair to be mobile? Yes ☐ No ☐
(4) What distance can the beneficiary ambulate? _____(feet)
(5) Does the beneficiary currently have a wheelchair? Yes ☐ No ☐
(6) How many hours per day is the manual wheelchair used? _____
(7) What is the age of the current wheelchair and who purchased it?

_____

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PRIOR AUTHORIZATION REQUEST (continued)

(8) What are the estimated repair costs or an explanation of why wheelchair cannot be repaired?

_____

_____

(9) How has the beneficiary been managing without a wheelchair up until now?

_____

_____

(10) What are the plans or options for the beneficiary if wheelchair is not provided?

_____

_____

(11) If the beneficiary is receiving a RENTAL WHEELCHAIR, is it:

☐ Used (in stock) ☐ New

Will the provider consider rental towards purchase of wheelchair? Yes ☐ No ☐

(If so, please include purchase price information with the request.)

The reimbursement approved includes the assembly of the wheelchair and all components of the wheelchair.

Wheelchair rental includes all repairs or modifications needed.

Provider Signature:_____ Date: _____

Fax completed forms to 1-800-913-2229 or 785-274-5956.
This form will be returned unprocessed if it is not completed in its entirety.
If this request is not received within 15 working days, PA will be denied.
Prior Authorization: 1-800-933-6593

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