

Algorithmic Approach to Coverage

Patient Name: _____ DOB _____

Address: _____ Phone: _____

Please answer the following line of questions to determine the appropriate Mobility Assistance Device. A copy of Medicare's Algorithmic Approach to Coverage is attached for your review.

- | | | |
|--|-----|---------------------------------|
| 1. Does patient have mobility limitation? | YES | NO |
| 2. Does patient have other limitations? | YES | NO |
| 3. Are other limitations compensated? | YES | NO |
| 4. Is patient capable of safe use of equipment? | YES | NO |
| 5. Can patient ambulate with a cane or walker? | YES | NO |
| 6. If "yes", is this mode of ambulation safe for patient? | YES | NO |
| 7. Is manual wheelchair appropriate for patient? | YES | NO |
| 8. If "yes", is manual wheelchair safe for patient? | YES | NO |
| 9. Which is most appropriate for patient?
<i>(please mark only one selection)</i> | | Motorized Wheelchair or Scooter |
| 10. If " scooter ", is scooter safe for patient? | YES | NO N/A |
| 11. If " power wheelchair ", is power wheelchair safe for patient? | YES | NO N/A |

Physician Signature

Date