PRISM HEALTH CARE SERVICES, INC.
MEDICAL SUPPLIES ▪ RESPIRATORY EQUIPMENT

FAX TO: 847-310-8051

LTC screen/Request for Custom Manual/Motorized Wheelchair Eval

Date: _____ Facility Name: _____

Facility Type: ☐ LTC ☐ Courts

Facility Contact Name: _____ Contact Email Address: _____

Therapist Contact Name: _____ Contact Email Address: _____

Resident Name: _____ Room # _____

Resident Payer Source:

☐ Medicare ☐ Public Aid ☐ Managed Care ☐ Other, Specify_____

Provider Preference: _____

Does Resident Have a Neuro or Ortho Diagnosis? ☐ Yes ☐ No

1. Where will the equipment be used?
   ☐ Long Term Care
   ☐ Discharge at Home

2. What is the recommendation for equipment?
   ☐ Manual ☐ Manual/Tilt ☐ Motorized

3. Does the resident require special seating/positioning? Yes ☐ No ☐
   If Answer is No, resident does not qualify for specialty seating evaluation)

4. Does the need include molded seat or molded back? Yes ☐ No ☐
   (If Answer is No, PA will not cover and another payer will be needed)

5. Fax the following documentation:

Motorized	Manual/Tilt	
X	X	*Request for Custom Manual/Power Wheelchair Evaluation Form*
X	X	*Resident Face Sheet*
X	X	*Physicians Order for Evaluation*

Prism will forward all documentation to Provider of Equipment and cc:

1. CPT Facility Supervisor to schedule a therapist for the evaluation.
2. Facility Representative

The Provider, CPT & Facility rep coordinate and confirm the evaluation date by email.

_____ _____

Completed by Therapist Printed Name Date

_____ _____

Completed by RN Printed Name Date