Mobility Equipment
Complex Manual or Power Wheelchair/Scooter
Prior Authorization/Requisition Form

The following information must be completed by the Requesting Physician in its entirety. Please attach all supporting documentation, if available. Limited information may delay your request. Once completed, please fax this form and all supporting documentation to Molina Healthcare Utilization Department at: 877-708-2117.

Requesting Physician: _____ **Phone:** _____

Physician Address: _____ **Fax:** _____

Physician City, State Zip:

MEMBER CONTACT INFORMATION

Patient Name: _____ **Molina Member ID#:** _____

DOB: _____ **Gender:** _____

Primary Address 1: _____ **Secondary Address 2 (Apt#)** _____

City: _____ **State:** _____ **Zip:** _____

Member Primary Phone #: **Member Secondary Contact Phone#:**

PRIMARY DIAGNOSIS

ICD-9 Code & ICD-9 Description	
CPT/HCPC Code & Description	

COMPLEX MANUAL /POWER WHEELCHAIR NEEDS (Complete if information available)

AVPU Scale / Level of Cognition: ***(Circle One: A+O=Alert and Oriented to self, place, time and circumstance)***

A+OX1 A+OX2 A+OX3 A+OX4 A, Not O Not A or O

Comments / Other: _____

Requested Equipment: ***(Circle One: PWC=Powered wheelchair; MWC=Manual wheelchair; W/C=Wheelchair)***

Scooter / POV Powered wheelchair Manual wheelchair Wheelchair Repairs W/C Modifications

Comments / Other: _____

Requested Accessories: **(Circle as many as necessary)**

Pressure Relief Cushion Tilt-in-space Recline Custom Seating Other:_____

Comments / Other: _____