### Standard Wheelchair

**Review Date** ____________________________  **PA #** ________________  [☐] Approved  [☐] Denied  
**Comments** ____________________________________________________________________________________________  **Signature** ____________________________

**Reconsideration Date** ________________  
**Comments** ____________________________________________________________________________________________  **Signature** ____________________________

- [☐] Patient is Medicaid eligible
- [☐] ACHN Referral
- [☐] EPSDT Screening if applicable
- [☐] Pull and print PAR screen to include in packet
- [☐] Physician’s Prescription
- [☐] Medical documentation of patient’s condition
- [☐] Ensure that wheelchair has not been authorized and purchased for patient in a period of less than five years
- [☐] If patient meets criteria, conditionally approve request until delivery ticket received—then do final approval

**Revised:** October 2019