Horizon Blue Cross Blue Shield of New Jersey

Date of Request: _____

In place of this Form you can submit Authorization Requests Online securely via Navinet. If you are not registered, please visit Navinet.net and click *Sign Up* or call Navinet Customer Care at **1-888-482-8057**.

Mobility Evaluation Report for Scooter

Fax completed form to: Horizon NJ TotalCare (HMO SNP) at 1-609-583-3013

Is this the: □ **Initial** □ **Replacement.** ***Reason:*** _____

Member Name: _____ **Member ID#** _____ **DOB:** _____

DME Provider: _____ **DME Provider Contact Name:** _____

DME Provider Contact Phone #: _____ **DME Provider Contact Fax#** _____

Current Symptoms, Related Diagnosis, and History

(must be completed by Treating Practitioner)

What medical conditions/disease limits your patient's mobility in their home?

□Cerebral Vascular Disease/CVA
□COPD
□CHF
□Degenerative Joint Disease
□Diabetes/Neuropathy
□Hemiplegia/Hemiparesis
□Multiple Sclerosis
□Muscular Dystrophy
□Osteoarthritis
□Other, Please Describe: _____
□Paraplegia/paresis
□Parkinson's Disease
□Renal Failure
□Rheumatoid Arthritis

How do the above conditions interfere with their ability to perform Activities of Daily Living (ADL's) in their home?

□Abnormality of Gait
□De-Conditioning
□Edema
□Other, Please Describe: _____
□Fatigue
□Numbness
□Pain
□Shortness of Breath
□Tremor
□Weakness

Physical Exam

(must be completed by Treating Practitioner)

Ht:	**Wt:**	**B/P**	**Pulse: (Resting):**	**Pulse: (Exertion)**
Shortness of Breath at Rest? Y N	**Shortness of Breath w/ exertion? Y N**	**Is O2 required? Y N**	**Number of Liters?**	**O2 Stats?**
Any current pressure sores? Y N	**History of pressure sores? Y N**	**Locations?**	**Stage?**	**Able to shift weight? Y N**
Poor Balance? Y N	**Poor Endurance? Y N**	**History of Falls? Y N**	**Risk of Falls? Y N**	**Significant Edema? Y N**

Upper Body Weakness:	_____Mild	_____Moderate	_____Severe	Gait Pattern:	_____Non-Ambulatory
Upper Body Pain:	_____Mild	_____Moderate	_____Severe		_____Max Assist
Lower Body Weakness:	_____Mild	_____Moderate	_____Severe		_____Mod Assist
Lower Body Pain:	_____Mild	_____Moderate	_____Severe		_____Ataxic
Contracture:	RUE/LUE				_____Shuffling

Horizon Blue Cross Blue Shield of New Jersey

Date of Request: _____

Member Name:_____ Member ID #:_____

1. **Please select all of the Activities on Daily Living (ADL's) that your patient is unable to perform inside their home without the aid of powered mobility equipment.**

   □Feeding □Dressing
   □Bathing □Toileting
   □Grooming □Other, Please Describe:_____
   □Moving Room to Room

2. **Why can't a cane or walker meet this patient's mobility needs in the home?**_____

   _____

   _____

3. **Why can't a manual wheelchair meet this patient's mobility needs in the home?**_____

   _____

4. **Describe how your patient's condition has changed so that they now require a Scooter to complete their ADL's**.

   _____

   _____

5. **Does your patient have the ability to sit erect?**
   □Yes □No

6. **Does your patient have the physical and mental abilities for safely operate a Scooter in the home?**
   □Yes □No

7. **Is your patient willing and motivated to use a Scooter in the home?**
   □Yes □No

8. **Does patient require a bariatric or heavy duty Scooter?** □Yes □No

9. **Is patient participating in a weight reduction program?**
   □Yes □No

I certify that the information provided is a true and accurate representation of my patient's current condition.
I hereby incorporate this document into my patient's medical record.

Signature:_____ ***Date:***_____
Physician or Treating Practitioner