**ADAPTIVE POSITIONING DEVICES**

**Instructions:** Complete all fields of this form to avoid delays and denials for requested services.

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| **Member Information** |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date of Birth: \_\_\_/\_\_\_\_/\_\_\_\_\_ | Medicaid ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Medical Condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Height: \_\_\_\_\_\_\_\_\_ | Weight**:** \_\_\_\_\_\_\_\_\_ |
| Transfer Technique: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Ambulatory Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Physical Plant of Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Type of Device Needed** |
| [ ]  Adaptive seating positioning device | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [ ]  Adaptive bed support  | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [ ]  Adaptive car support | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Type of Accessories Needed (Check All That Apply)** |
| [ ]  Adjustable armrests | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [ ]  Adjustable leg rests | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [ ]  Foot platform | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [ ]  Lateral supports | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [ ]  Pelvic belt | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [ ]  Chest harness | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [ ]  Pommel | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [ ]  Tray | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ☐ Backrest | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ☐ Wheeled | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ☐ Head support | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ☐ Reclining | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ☐ Tilt in space | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ☐ High-low base | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ☐ Outdoor base | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [ ]  Other | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Successful trial:**  | [ ]  Yes [ ]  No |
| **Other devices trialed/considered that did not meet medical need:** |
| Commercially available devices: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Adaptive devices: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Assessment:** |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Therapist Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Therapist Contact Info: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |