

**State of Louisiana Medicaid
Repair form for Custom Wheelchairs**

Instructions:

1. The Prior Authorization (PA-01) and Repair Form for Custom Wheelchairs are required with all repair requests.
2. Writing must be legible.
3. All sections must be completed by the technician and specifically state why each part needs to be replaced.
4. Attach Physician script and itemized manufacture price sheets.
5. List the parts needed in order of the manufacture price sheets.

I. GENERAL INFORMATION:

Date of service call: _____
Beneficiary's Name: _____ DOB: _____
Beneficiary's Address: _____
Medicaid ID #: _____

II. PRESENT WHEELCHAIR NEEDING REPAIRS:

Does the beneficiary currently own the wheelchair needing repairs: ☐ Yes ☐ No
Serial #: _____ Date provided: _____
Model: _____ Type: ☐ Manual ☐ Power
Size: _____ Price: _____
Who paid for the wheelchair? _____
Wheelchair base current condition: ☐ Good ☐ Fair ☐ Poor
Does the wheelchair currently have growth? ☐ Yes ☐ No
Do the items need repair due to abuse or misuse? ☐ Yes ☐ No
Are the items in need of repair under warranty? ☐ Yes ☐ No
If yes, list the parts: _____
Does the beneficiary still use the wheelchair? ☐ Yes ☐ No

III: PROVIDE THE FOLLOWING IF LABOR IS NEEDED FOR GROWTH, REPLACEMENT OF THE BACKREST AND/OR SEAT CUSHION:

Beneficiary's current height: _____ Current weight: _____
Current hip width: _____ Seat depth: _____ Back height: _____ Knee to heel: _____

IV. PARTS NEEDED:

Wheelchair Part Description/Part number: _____
Reason for repair: _____

Labor to repair the wheelchair part: _____ Quantity: _____

Wheelchair Part Description/Part number: _____
Reason for repair: _____

Labor to repair the wheelchair part: _____ Quantity: _____

Wheelchair Part Description/Part number: _____
Reason for repair: _____

Labor to repair the wheelchair part: _____ Quantity: _____

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Wheelchair Part Description/Part number: _____
Reason for repair: _____

Labor to repair the wheelchair part: _____ Quantity: _____

I, _____, personally examined and documented repairs for the
beneficiary's wheelchair and confirm that the above repairs are necessary for proper functioning
of the beneficiary's custom wheelchair.

Technician Signature/ Credentials:

Date