Client Name _____ **Client Medicaid Number** _____ **Date** _____

Provider Name *Wheelchairs Plus* **Provider Medicaid NPI / TPI#** *1417041948 / 016062402*

Provider Phone # *(210) 949-1660* **Provider Fax #** *(210) 949-0434*

STANDERS/GAIT TRAINERS/WALKERS

Remarks: ☐ Urgent ☐ For Your Review ☐ Reply ASAP ☐ Please comment

For all standers, gait trainers, or walkers please submit the following information:

1. **Client height and weight / condition and functional level/ ambulating potential.** _____
2. **Anticipated benefits from requested equipment.** _____
3. **Anticipated length of time client will require this equipment. Please address growth potential of requested item.** _____
4. **Where will equipment be used? Home_____ School_____ Outpatient Therapy _____**
5. **Frequency and amount of time of standing / walking program.** _____
6. **Specific manufacturer's information for the item being requested. Please include line by line price list of equipment and accessories. Medical documentation for accessories required.** _____
7. **Other medical documentation pertinent to reviewing this request.** _____

X _____ Date: _____

Signature of clinician completing form

Please send the above medical documentation to Home Health with a completed Title XIX form.