Utah Department of
Health & Human Services
Integrated Healthcare

Wheelchair Final Evaluation Form

Must be completed within 10 business days of delivery date
See Medical Supplies and Durable Medical Equipment Manual for criteria related to this form

Member's Name: _____

Member's Medicaid ID Number: _____

Tracking Number for Wheelchair: _____

VENDOR

The frame, accessories, attachments, components, and options are present, upon delivery, as approved on the prior authorization? ☐ YES ☐ NO

_____ _____ _____
Vendor Name (print) Vendor Signature Today's Date

THERAPIST EVALUATION

Does the wheelchair fit the member properly? ☐ YES ☐ NO

Document the member/caregiver is appropriately trained on the proper use and function, and demonstrates the ability to safely and efficiently operate this wheelchair? ☐ YES ☐ NO

Therapist performing final evaluation:

_____ _____ _____
Therapist's Name (print) Therapist's Signature Today's Date

MEMBER'S STATEMENT*

The wheelchair that I received fits my needs. ☐ YES ☐ NO

The wheelchair is what I was told would be ordered. ☐ YES ☐ NO

The training was completed and I am comfortable operating the newly delivered wheelchair. ☐ YES ☐ NO

_____ _____ _____
Member's Name* (print) Member's Signature* Today's Date

*Caregiver when applicable

After completion of the final evaluation, include this form with the claim submission and fax to 801-536-0481.

Updated January 2020