Print Form

CalOptima Health

WHEELCHAIR REPAIRS
Authorization Referral Form

Fax information to CalOptima Health at 714-481-6516

MEMBER INFORMATION

Patient Name: _____ Date of Birth: _____ Age: _____
(First) (MI) (Last)

Medi-Cal Number (CIN): _____ Gender: ☐ Female ☐ Male

Patient Address: _____ City: _____ Zip: _____ Phone: _____

☐ Home ☐ Board and Care ☐ ICF-DD ☐ SNF ☐ Other: _____

Facility Name: _____ Contact: _____

Language: Patient Speaks: _____ Patient Understands: _____

Caregiver / Family member participating in assessment and fitting ☐ YES ☐ NO ☐ N/A If yes, language spoken: _____

PRESCRIPTION

(Rx must be completed, signed, and dated by attending physician.)

Prescribing Physician: _____

Medi-Cal Provider ID # _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Primary Dx: _____ ICD-9: _____ Current Functional Status: _____

Current Wheelchair: ☐ Manual ☐ Power ☐ Tilt/Recline Year: _____ Serial #: _____

Brief description of services needed:

M. D. Signature: _____ License No: _____ Date: _____

PRINT Name: _____

CALOPTIMA HEALTH TO ASSIGN DME VENDOR