

A GUIDE FOR PATIENTS & CAREGIVERS

Getting Your Power Wheelchair Approved

How to Navigate Medicare, Medicaid, and Private Insurance

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What this guide covers

The medical-necessity standard every insurer uses to evaluate a power wheelchair request.

Step-by-step approval processes for Medicare, Medicaid, and commercial insurance.

A complete documentation checklist you can bring to your doctor's appointment.

The most common reasons claims get denied — and how to appeal successfully.

Introduction

If you or a loved one needs a power wheelchair, the equipment itself is usually the easy part — the harder part is convincing an insurance company to pay for it. Power wheelchairs are expensive, and every payer, whether it's Medicare, a state Medicaid program, or a private health plan, requires proof that the device is medically necessary before it will approve coverage.

That proof-gathering process can feel overwhelming: face-to-face exams, written orders, mobility evaluations, prior authorization, specific billing codes, and strict deadlines. Miss one piece and the whole request can be delayed or denied. This guide walks you through exactly what each type of insurance requires, in plain language, so you and your care team can get it right the first time — and know what to do if you don't.

This guide is written for patients, family members, and caregivers. It is educational, not legal or medical advice, and coverage rules change and vary by plan and state. Always confirm current requirements with your specific insurer and your DME (durable medical equipment) supplier.

The One Standard Every Insurer Uses: "Medical Necessity"

Regardless of who is paying — Medicare, Medicaid, or a private plan — approval comes down to one central question: is this power wheelchair medically necessary for you to complete everyday activities in your home? Insurers are not asking whether a power wheelchair would be convenient or would improve your quality of life in general. They are asking a narrower question, and your documentation needs to answer it directly.

Across nearly all payers, medical necessity for a power wheelchair generally requires showing all of the following:

1. A significant mobility limitation that prevents you from safely completing daily activities in your home — such as toileting, bathing, dressing, grooming, or getting to the kitchen — within a reasonable amount of time.
2. That a cane or walker cannot safely resolve the problem.
3. That you do not have the strength, endurance, or coordination to self-propel a manual wheelchair for those same activities.
4. That you (or a willing, available caregiver) can safely operate the power wheelchair.
5. That your home has enough space and appropriate surfaces for the device to be used.
6. That the wheelchair will actually be used inside the home to complete daily activities — not only for outings or appointments.

That last point trips up a surprising number of applications. Documentation that focuses on getting to doctor's appointments or getting around town, without addressing mobility inside the home, is one of the most common reasons requests are denied. Every conversation with your doctor should center on what is hard to do at home.

How the Three Payer Types Compare

	Medicare	Medicaid	Commercial / Private Insurance
Who runs it	Federal program (CMS)	State-run, federal/state funded	Private insurance companies
Core standard	"Medical necessity" under national LCD criteria	"Medical necessity" under state-specific rules	"Medical necessity" under each plan's policy

	Medicare	Medicaid	Commercial / Private Insurance
Face-to-face exam required	Yes — within 6 months before the order	Yes, in nearly all states	Usually yes
Prior authorization	Required for most power wheelchairs	Required in most states	Required by most plans
Typical review time	~10 business days (expedited available)	30–90 days, varies by state	7 days standard / 72 hours urgent
Appeals path	Redetermination → reconsideration → ALJ hearing → further review	State fair hearing process	Internal appeal → external review (IRO)

Medicare: Step-by-Step

Medicare Part B covers power wheelchairs as durable medical equipment when criteria are met, but the process is document-heavy and closely timed. Here is the sequence in order.

Step 1 — Face-to-face examination

Your physician must examine you in person within the 6 months before the wheelchair is ordered. The visit must address your mobility limitations, why a cane or walker will not work, and why a manual wheelchair is not sufficient. A telehealth visit or a visit focused only on an unrelated issue typically will not satisfy this requirement.

Step 2 — Standard Written Order (SWO)

After the face-to-face exam, your physician issues a written order for the base equipment. This order cannot come before the exam — Medicare requires the exam to establish the need first.

Step 3 — Specialty evaluation (for higher-level chairs)

For more advanced power wheelchairs (Medicare's "Group 2" chairs with power seating options and "Group 3" chairs), a physical therapist, occupational therapist, or other qualifying clinician must complete a specialty mobility evaluation documenting exactly why those specific features are medically necessary for you.

Step 4 — Prior authorization

Most power wheelchairs require prior authorization before delivery. Your DME supplier submits your medical records, the written order, and the mobility evaluation to Medicare for review. Medicare typically responds within about 10 business days for a standard request. If the request is approved, you'll receive a unique tracking number — delivery without that number is one of the most common causes of automatic denial.

Step 5 — Home assessment and delivery

Before or at the time of delivery, your supplier confirms your home has adequate space and surfaces for the chair to be used safely. Delivery must occur within 120 days of the face-to-face exam and within 6 months of prior authorization approval.

What it costs

After you meet your Part B deductible, you typically pay 20% of the Medicare-approved amount, as long as your supplier accepts Medicare assignment. Choosing a supplier that is Medicare-enrolled and participates in assignment protects you from being billed above the approved amount. If you have a Medicare Advantage plan, contact your plan directly, since rules and networks differ from Original Medicare.

Medicare timing cheat sheet

Face-to-face exam: within 6 months before the written order

Medical records submission: within 45 days of the face-to-face exam

Delivery: within 120 days of the face-to-face exam

Delivery after prior authorization approval: within 6 months

Medicaid: Step-by-Step

Medicaid also covers power wheelchairs as medically necessary equipment, but because Medicaid is administered by each state, the specific rules, forms, and timelines vary. A few things are true almost everywhere:

- You will need a face-to-face examination and physician certification, similar to Medicare.
- A functional/mobility assessment is required showing why a manual wheelchair will not work.
- Prior authorization is required in most states, and review typically takes 30 to 90 days — plan ahead.
- Many states weigh community integration heavily, especially under Home and Community-Based Services (HCBS) waivers, so documentation that addresses moving safely within the home and community can matter more than it does for Medicare.
- If you're enrolled in both Medicare and Medicaid ("dual eligible"), Medicare is typically billed first and Medicaid may cover remaining costs or equipment Medicare doesn't fully cover.

Because requirements differ by state — some states require competitive bidding among suppliers, others emphasize specific functional assessment forms — it's worth calling your state Medicaid office or your DME supplier early to confirm exactly what documentation your state requires before you schedule the physician visit.

Private / Commercial Insurance: Step-by-Step

Private insurance plans generally follow a similar overall shape to Medicare and Medicaid, but the specific forms and definitions of "medical necessity" are set by each individual plan, so always check your plan's specific policy.

1. Get a face-to-face evaluation. Your physician documents your mobility limitations in person — this cannot be replaced by a phone call or old notes.
2. Complete a Certificate of Medical Necessity (CMN). Many private plans use a CMN form, completed by your physician, that documents your diagnosis and functional limitations.
3. Gather supporting records. Physician notes, relevant test results, and documentation of mobility aids you've already tried (cane, walker, manual chair) all strengthen the request.
4. Confirm your supplier is in-network. Using an out-of-network DME supplier can result in denial or much higher out-of-pocket costs — verify network status and accreditation before ordering equipment.
5. Submit for prior authorization before ordering. Ordering the equipment before authorization is approved is one of the fastest ways to have an otherwise-valid claim denied outright.

Standard prior authorization decisions are generally required within 7 calendar days, and urgent requests within 72 hours. Many states also have a "deemed approved" rule: if the insurer misses its own deadline, the request is automatically approved — worth knowing if a decision is taking unusually long.

Universal Documentation Checklist

Regardless of payer, gathering the following before your appointment will cover nearly everything an insurer is likely to ask for. Bring this list to your physician visit.

☐	Recent face-to-face examination note (within the last 6 months) addressing mobility limitations specifically
☐	Physician's written order / prescription for a power wheelchair (signed and dated)
☐	Diagnosis and history explaining the underlying medical condition
☐	Documentation that a cane or walker is not sufficient
☐	Documentation that a manual wheelchair is not sufficient (strength, endurance, or coordination limitations)
☐	Specialty mobility evaluation from a PT/OT, for higher-level power chairs
☐	Description of specific daily activities affected at home (bathing, dressing, toileting, meal prep, moving between rooms)
☐	Confirmation you or a caregiver can safely operate the device
☐	Home assessment confirming adequate space and surfaces
☐	Certificate of Medical Necessity (CMN), if your payer requires one
☐	Correct HCPCS billing/product codes for the specific chair and features
☐	Proof of Medicare/Medicaid enrollment or in-network status for your DME supplier

Common Reasons Claims Get Denied

Knowing what trips up other applications is the best way to avoid the same mistakes:

- Missing or outdated face-to-face exam — a visit older than the payer's window, or one that doesn't specifically address home mobility.
- Documentation that focuses on transportation or appointments rather than daily activities inside the home.
- Incomplete paperwork — missing signatures, missing product codes, or records that don't clearly connect the diagnosis to the need for a power (rather than manual) wheelchair.
- Ordering equipment before prior authorization is approved.
- Using a supplier that isn't Medicare-enrolled, Medicaid-approved, or in-network for your private plan.
- Missing submission deadlines — for example, Medicare requires medical records within 45 days of the face-to-face exam and delivery within 120 days.
- Requesting a replacement chair without documenting a changed medical condition or that the original chair is damaged beyond repair.

If You're Denied: How to Appeal

A denial is not the end of the road — a large share of power wheelchair denials are overturned on appeal, especially when the appeal directly addresses the stated reason for denial rather than simply resubmitting the same paperwork.

1. Read the denial letter closely

The letter must state the specific reason for denial. That reason is your roadmap — your appeal needs to directly answer it, not just restate that you need the chair.

2. Call your insurer

Ask exactly what documentation would resolve the denial. This one call can save weeks of back-and-forth.

3. Strengthen the medical record

Work with your physician (and PT/OT, if applicable) to add a detailed letter of medical necessity that speaks specifically to your daily, in-home mobility challenges — with concrete examples, not general statements.

4. File your appeal in writing, and on time

Private insurance: you typically have 180 days to file an internal appeal. Medicare: you have 120 days to request a redetermination. Medicaid: your state's deadline will be listed in the denial notice — file promptly.

5. Escalate if needed

If the internal appeal is denied, you can generally request an independent, binding external review (private insurance), a Medicare reconsideration and, if necessary, a hearing before an Administrative Law Judge, or a state fair hearing (Medicaid). These outside reviewers are independent of the insurer and can overturn the original decision.

Keep a paper trail

Log every call: date, who you spoke with, and what they said.

Save copies of everything you submit and every letter you receive.

Follow up in writing after phone calls to confirm what was discussed.

Ask your DME supplier to help track prior authorization and appeal status — this is part of what a good supplier does for you.

How Moving Forward DME Can Help

Navigating this process alone is hard, and you don't have to. As your DME supplier, Moving Forward DME can help coordinate with your physician's office, confirm exactly which documentation your specific payer requires, track prior authorization status, and manage appeals if a claim is denied. If you or a loved one needs a power wheelchair, reach out to our team and we'll walk through the process with you step by step.

Sources

This guide summarizes publicly available guidance from the following sources. Coverage rules change, so always confirm current requirements with your insurer.

- Centers for Medicare & Medicaid Services — Power Mobility Devices Local Coverage Determination (L33789)
- Medicare.gov — Medicare Coverage of Wheelchairs & Scooters
- Medicare Rights Center — Medicare Advocacy Toolkit: Power Wheelchairs
- Noridian Healthcare Solutions — Documentation Checklist for Power Mobility Devices
- LegalClarity — Medicare Guidelines for Wheelchair Coverage; How to Get a Wheelchair Through Insurance Coverage; Prior Authorization Rules, Timelines, and Appeals