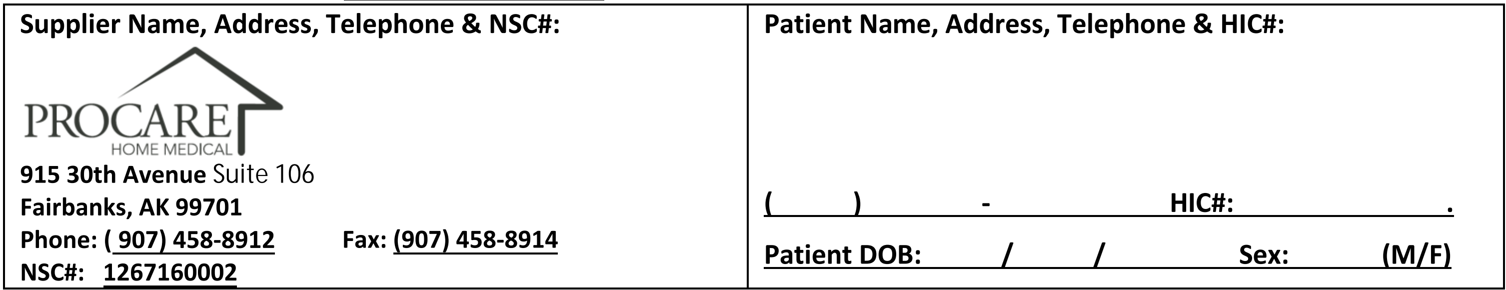
℞ **WRITTEN ORDER AND MEDICAL JUSTIFICATION**
SEAT LIFT MECHANISM (LIFT CHAIR)

Date of Last Provider Visit__________________



Supplier Name, Address, Telephone & NSC#:	**Patient Name, Address, Telephone & HIC#:**
PROCARE HOME MEDICAL **915 30th Avenue** Suite 106 **Fairbanks, AK 99701** **Phone: (907) 458-8912** **Fax: (907) 458-8914** **NSC#: 1267160002**	**( ) - HIC#: .** **Patient DOB: / / Sex: (M/F)**

We have been asked to provide the following equipment to the patient named above. Please review and verify this information by completing any of the highlighted areas, and date and sign at the bottom. We suggest you keep a copy of this for your records.

Lift Chair:

Diagnosis and Code: ______________________________

Length of Need (# of months): ___________1-99 (99=life)

Patient Height: ___________ft. in. Weight: _______ lbs.

❑ Lift Chair (Frame Only) (A9270)
❑ Seat Lift Mechanism (Lift Chair) (E0627)
Note: Insurance will generally only cover the lift mechanism.

MEDICAL NECESSITY INFORMATION:

REQUIRED CRITERIA

1. Does the patient have severe arthritis of the hip or knee or have a severe neuromuscular disease?
   ❑ Y ❑ N
2. Is the seat lift mechanism part of the course of treatment? *Note: The lift mechanism must be prescribed to effect improvement, or arrest or retard deterioration in the patient's condition.*
   ❑ Y ❑ N
3. Is the patient completely incapable of standing up from a regular armchair or any chair in their home?
   ❑ Y ❑ N
4. Once standing, does the patient have the ability to ambulate?
   ❑ Y ❑ N

PROVIDER CERTIFICATION:

I, the patient's treating provider, certify the medical necessity of these items for this patient and maintain medical records reflecting the medical justification and care provided.

____
Provider's Signature Date

____
Provider's Name

NPI: _________________ Telephone: ________________

Updated 07-23-20