


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

Date of Last Provider Visit _____

Supplier Name, Address, Telephone & NSC#:  901 N Leatherleaf Loop Suite 104 Wasilla, AK 99654 Phone: (907) 357-7882 Fax: (907) 357-7883 NSC#: 1267160003	Patient Name, Address, Telephone & HIC#: () - 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: _____

Date of Service: _____

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: _____