℞ WRITTEN ORDER AND MEDICAL JUSTIFICATION
PATIENT LIFT

Date of Last Provider Visit_____

Supplier Name, Address, Telephone & NSC#:	**Patient Name, Address, Telephone & HIC#:**
PROCARE HOME MEDICAL **901 N Leatherleaf Loop** **Wasilla, AK 99654** **Phone: (907) 357-7882** **Fax: (907) 357-7883** **NSC#: 1267160003**	**( ) - 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.

PATIENT LIFT:

Diagnosis and Code: _____

Length of Need (# of months): _____1-99 (99=life)

Patient Height: _____ft. in. Weight: _____ lbs.

Standard Equipment

☐ Patient Lift, Manual, 450 lb max (E0630)
☐ Patient Lift, Electric, 450 lb max (E0635)
Note: Electric Lifts require a Prior Authorization (PA) before equipment may be dispensed.

☐ Sling without Commode Opening
☐ Sling with Commode Opening

☐ Other: _____

Bariatric Equipment

☐ Patient Lift, Electric, HD, 600 lb max (E0635)
Note: Electric Lifts require a Prior Authorization (PA) before equipment may be dispensed.

☐ Sling without Commode Opening
☐ Sling with Commode Opening

☐ Other: _____

MEDICAL NECESSITY INFORMATION:

REQUIRED CRITERIA

1. Is transfer between bed and a chair, wheelchair, or commode required?
☐ Y ☐ N

AND

2. Would patient be bed confined without the use of a lift?
☐ 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: _____