


**R WRITTEN ORDER AND MEDICAL JUSTIFICATION  
BATHROOM SAFETY**

Date of Last Provider Visit \_\_\_\_\_

<b>Supplier Name, Address, Telephone &amp; NSC#:</b>  <b>3519 Industrial Avenue Fairbanks, AK 99701 Phone: (907) 458-8912      Fax: (907) 458-8914 NSC#: 1267160002</b>	<b>Patient Name, Address, Telephone &amp; HIC#:</b>  (____) _____ - _____ HIC#: _____ <b>Patient DOB: _____ / _____ / _____      Sex: _____ (M/F)</b>
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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.

**BATHROOM SAFETY ITEMS:**

Date of Service: \_\_\_\_\_

Diagnosis and Code: \_\_\_\_\_

Length of Need (# of months) \_\_\_\_\_ 1-99 (99=life)

Patient Height: \_\_\_\_\_ ft. in.    Weight: \_\_\_\_\_ lbs.

**Standard Equipment**

- Commode, Bedside (3 in 1), 300 lb (E0163)
- Commode, Drop Arm, 250 lb (E0165)

*Note: The Following items are generally not covered by insurance.*

- Raised Toilet Seat (RTS), 300 lb (E0244)
- Raised Toilet Seat (RTS) with Arms, 300 lb (E0244)
- Shower Chair without Back, 400 lb (E0240) Shower Chair with Back, 400 lb (E0240)
- Bath Board, 330 lb (E0245)
- Toilet Safety Frame (Versa Frame), 250 lb (E0243)
- Grab Bar (E0241)
- Tub Transfer Bench (TTB) E0247

**Bariatric Equipment**

- Commode, Bedside, HD, 450 lb (E0168)
- Commode, Drop Arm, HD 600 lb (E0165)

*Note: The Following items are generally not covered by insurance.*

- Transfer Tub Bench (TTB), 400 lb (E0248)
- Shower Chair with Back, 700 lb (E0240)
- Raised Toilet Seat (RTS), HD, 500 lb (E0244)

**MEDICAL NECESSITY INFORMATION:**

**REQUIRED CRITERIA**

1. The patient is confined to a single room.  
 Y    N

**OR**

2. The patient is confined to one level of the home environment and there is no toilet on that level.  
 Y    N

**OR**

- 3. The patient is confined to the home and there are no toilet facilities in the home.  
 Y    N
- 4. The patient is unable to lower and rise without assistance.  
 Y    N
- 5. The patient is at risk of fall and injury due to physical and/or neurological limitations.  
 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: \_\_\_\_\_