


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

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

<p><b>Supplier Name, Address, Telephone &amp; NSC#:</b></p>  <p>901 N Leatherleaf Loop Wasilla, AK 99654 Phone: (907)357-7882 Fax: (907) 357-7883 NSC#: 1267160003</p>	<p><b>Patient Name, Address, Telephone &amp; HIC#:</b></p> <p>(____) _____ - _____ HIC#: _____</p> <p>Patient DOB: ____/____/____ Sex: ____ (M/F)</p>
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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:**

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 max (E0163)
- Commode, Drop Arm, 300 lb max (E0165)

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

- Raised Toilet Seat (RTS), 300 lb max (E0244)
- Raised Toilet Seat (RTS) with Arms, 300 lb max (E0244)
- Shower Chair/Bath Stool, 300 lb max (E0245)
- Toilet Safety Frame (Versa Frame), 250 lb max (E0243)
- Grab Bar (E0241)
- Tub Transfer Bench (TTB) 300 lb max (E0247)

**Bariatric Equipment**

- Commode, Bedside, HD, 450 lb max (E0168)
  - Commode, DropArm, HD 650 lb max (E0165)
- Note: The Following items are generally not covered by insurance*

- Transfer Tub Bench (TTB), 500 lb max (E0248)
- Shower Chair /Bath Stool, 500 lb max (E0245)

**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: \_\_\_\_\_