


**R WRITTEN ORDER AND MEDICAL JUSTIFICATION
PATIENT LIFT**

Date of Last Provider Visit _____

<p>Supplier Name, Address, Telephone & NSC#:</p> <div style="text-align: center;"> PROCARE HOME MEDICAL</div> <p>3519 Industrial Avenue Fairbanks, AK 99701 Phone: (907) 458-8912 Fax: (907) 458-8914 NSC#: <u>1267160002</u></p>	<p>Patient Name, Address, Telephone & HIC#:</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.

PATIENT LIFT:

Date of Service: _____

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 (E0630)

Patient Lift, Electric, 450 lb (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 (E0635)

Note: Electric Lifts require a Prior Authorization (PA) before equipment may be dispensed.

Sling without Commode Opening, HD, 600lb

Sling with Commode Opening, HD, 600lb

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: _____