℞ CLARIFICATION OF WRITTEN ORDER AND MEDICAL JUSTIFICATION
SEAT LIFT MECHANISM (LIFT CHAIR)

Date of Last Provider Visit_____

Supplier Name, Address, Telephone & NSC#:	**Patient Name, Address, Telephone & HIC#:**
PROCARE HOME MEDICAL **713 Northway Dr.** **Anchorage, AK 99508** **Phone: (907) 274-0770** **Fax: (907) 274-0773** **NSC#: 1267160001**	**( ) - HIC#: .** **Patient DOB: / / Sex: (M/F)**

An order was received on _____ for the services/equipment provided to the above named patient. In order to properly bill for the services/equipment provided we require a revised detailed written order. 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. Prepared by:_____

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: _____