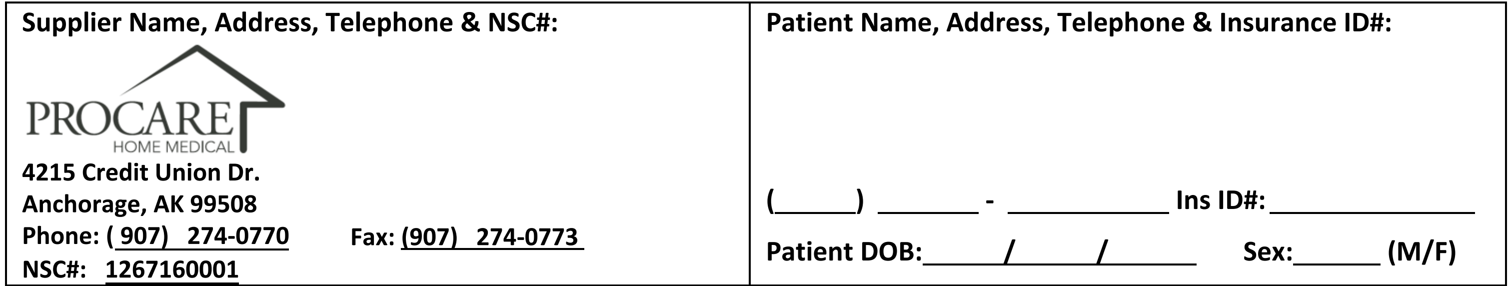
℞ WRITTEN ORDER AND MEDICAL JUSTIFICATION
BATHROOM SAFETY

Date of Last Provider Visit__________________



Supplier Name, Address, Telephone & NSC#:	**Patient Name, Address, Telephone & Insurance ID#:**
PROCARE HOME MEDICAL **4215 Credit Union Dr.** **Anchorage, AK 99508** **Phone: (907) 274-0770 Fax: (907) 274-0773** **NSC#: 1267160001**	**(_____) _______ - ___________ Ins ID#:_______________** **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.

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: ________________