℞ WRITTEN ORDER AND MEDICAL JUSTIFICATION
BATHROOM SAFETY

Date of Last Provider Visit_____

Supplier Name, Address, Telephone & NSC#:	**Patient Name, Address, Telephone & HIC#:**
PROCARE HOME MEDICAL **901 N. Leatherleaf Loop Suite 104** **Wasilla, AK 99654** **Phone: (907)357-7882 Fax: (907) 357-7883** **NSC#: 1267160003**	**(_____) _____ - _____ HIC#:_____** **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:

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: _____