PATIENT LIFT STANDARD WRITTEN ORDER

PROCARE HOME MEDICAL **Please fax to:** **Anchorage (907) 274-0773** **Fairbanks (907) 458-8914** **Soldotna (907) 260-3757** **Wasilla (907) 357-7883** **or email to:** **dme@procarehm.com**	**Patient Name, Address, Telephone & Insurance ID #:** Phone: **Ins ID #:** **Patient DOB: Sex: (M/F)**

Refer to patient lift coverage criteria sheet for all required documentation.

PATIENT LIFT:

Date of Last Visit: _____ Order Date: _____

Diagnosis and Code: _____

Length of Need (# of months): _____ 1-99 (99=lifetime) Patient Height: in. _____ Weight: lbs. _____

Standard Equipment

☐ Patient Lift, Manual with sling, 450 lb max (E0630)

☐ Replacement Sling (E0621)

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: _____ NPI: _____

Provider's Name: _____ Telephone: _____