


**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>4215 Credit Union Dr. Anchorage, AK 99503 Phone: (907) 274-0770 Fax: (907) 274-0773 NSC#: 1267160001</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: _____

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 max (E0630)
- Patient Lift, Electric, 450 lb max (E0635)
- Note: Electric lifts are non-covered by most insurances. Will require a Prior Authorization(PA) before equipment is dispensed.
- Sling without Commode Opening
- Sling with Commode Opening
- Other: _____

Bariatric Equipment

- Patient Lift, Electric, HD, 600 lb, max (E0635)
- Note: Electric Lifts require a Prior Authorization (PA) before equipment may be dispensed.
- Sling without Commode Opening
- Sling with Commode Opening
- 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: _____