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.

Date of Last Visit: _____

PATIENT LIFT:

Diagnosis and Code: _____ Patient Height: _____ in. Weight: _____ lbs.

Length of Need (# of months): _____ 1-99 (99=lifetime) Order Date: _____

Standard Equipment

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

Sling specification: _____

(Patient preference if not specified)

☐ Replacement Sling (E0621)

Sling specification: _____

(Patient preference if not specified)

MEDICAL NECESSITY INFORMATION: *Must also be supported in medical records, if applicable*

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: _____ NPI: _____

Provider's Name: _____ Telephone: _____