SEAT LIFT MECHANISM (LIFT CHAIR) 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 the lift chair coverage criteria sheet for all required documentation.

Date of Last Visit: _____

Lift Chair:

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

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

☐ Reclining Lift Chair (A9270/E0627)

Note: If ordering a lift chair both components need to be selected

☐ Frame only (A9270)

☐ Seat Lift Mechanism only (E0627)

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

1. Does the patient have severe arthritis of the hip or knee or have a severe neuromuscular disease? ☐ Y ☐ N

2. Is the seat lift mechanism part of the course of treatment? ☐ Y ☐ N
   Note: The lift mechanism must be prescribed to effect improvement, or arrest or retard deterioration in the patient's condition.

3. Is the patient completely incapable of standing up from a regular armchair or any chair in their home? ☐ Y ☐ N

4. Once standing, does the patient have the ability to ambulate? ☐ 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: _____