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.

Lift Chair:

Date of Last Visit: _____ Order Date: _____

Diagnosis and Code: _____

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

Reclining Lift Chair with seat lift mechanism (A9270/E0627)

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: _____