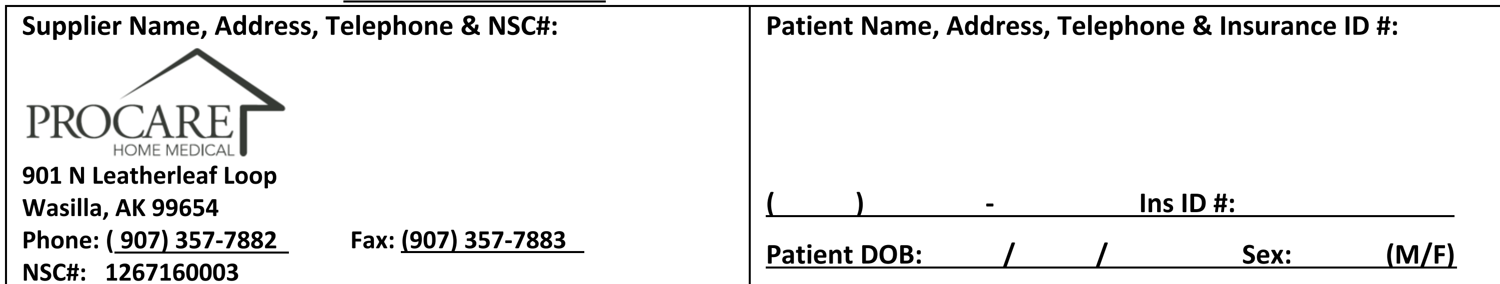
# ℞ WRITTEN ORDER AND MEDICAL JUSTIFICATION PATIENT LIFT

**Date of Last Provider Visit__________________**



| **Supplier Name, Address, Telephone & NSC#:** | **Patient Name, Address, Telephone & Insurance ID #:** |
|---|---|
| PROCARE HOME MEDICAL<br>**901 N Leatherleaf Loop**<br>**Wasilla, AK 99654**<br>**Phone: ( 907) 357-7882 Fax: (907) 357-7883**<br>**NSC#: 1267160003** | **(     )          -          Ins ID #:**<br>**Patient DOB:   /   /   Sex:   (M/F)** |

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: ________________

Updated 12-28-20