


**PATIENT LIFT STANDARD WRITTEN ORDER**

 <p>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</p>	<b>Patient Name, Address, Telephone &amp; Insurance ID #:</b>
	Phone: _____ Ins ID #: _____ Patient DOB: _____ Sex: (M/F) _____

Refer to patient lift coverage criteria sheet for all required documentation.

**PATIENT LIFT:**

Date of Last Visit: \_\_\_\_\_ Order Date: \_\_\_\_\_

Diagnosis and Code: \_\_\_\_\_

Length of Need (# of months): \_\_\_\_\_ 1-99 (99=lifetime) Patient Height: in. \_\_\_\_\_ Weight: lbs. \_\_\_\_\_

**Standard Equipment**

Patient Lift, Manual with sling, 400 lb max (E0630)

Replacement Sling (E0621)

**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: \_\_\_\_\_