CONFIRMATION OF ORDER — Lift Chair

PROVIDER: Home Health Solutions
501 East Sloan Street
Harrisburg, IL 62946

phone: 618-252-5349
fax: 618-252-2445

NPI: 1215337266
Tax ID #: 371124259

Patient: _____ **Date of Birth:** _____

Order Date: _____ **Insurance:** _____

Length of Need: 99 *(in months)*

Physician: _____ **NPI:** _____

DIAGNOSIS

ICD 10 Code	Description

EQUIPMENT/SERVICES

Quantity	Proc. Code	Item Name/Narrative
1	E0627	Lift Chair

ADDITIONAL MEDICAL INFORMATION *(please check **Y** for Yes, **N** for No or **D** for Does Not Apply)*

☐ Y ☐ N ☐ D Does the patient have severe arthritis of the hip or knee?

☐ Y ☐ N ☐ D Does the patient have a severe neuromuscular disease?

☐ Y ☐ N ☐ D Is the patient completely incapable of standing up from a regular armchair or any chair in his/her home?

☐ Y ☐ N ☐ D Once standing, does the patient have the ability to ambulate?

☐ Y ☐ N ☐ D Have all appropriate therapeutic modalities to enable the patient to transfer from a chair to a standing position *(e.g., medication, physical therapy)* been tried and failed? If YES, this is documented in the patient's medical records.

PERSON COMPLETING FORM *(if someone other than physician)*

Name: _____

Title: _____ **Employer:** _____

Physician Signature: _____ **Date:** _____