CONFIRMATION OF ORDER — Lift Chair

PROVIDER: Medicine Shoppe #503
304 South Commercial
Harrisburg, IL 62946-2108

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

NPI: 1528178720
Tax ID #: 371124259

Patient: **Date of Birth:**

Order Date: **Insurance:**

Length of Need: 99 *(in months)* **Patient Height:** **Patient Weight:**

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 seat lift mechanism a part of the course of treatment and prescribed to effect improvement, or arrest or retard deterioration in the patient's condition?

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:** ____________________