Patient Information

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_Zip\_\_\_\_\_\_

Primary Insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Discharge Date\_\_\_\_\_\_\_\_\_\_\_\_ Height\_\_\_\_\_\_\_Weight\_\_\_\_\_\_Diagnonsis Codes\_\_\_\_\_\_\_\_\_\_\_\_\_Length of Need(# of Months)\_\_\_\_\_\_\_\_1-99 (99=Lifetime)

Bathroom Safety

| Standard Equipment* Commode, Bedside (3 in 1), 350 lb max (E0163)
* Commode, Drop Arm, 300 lb max (E0165)

*Note: The following items are generally not covered by insurance** Raised Toilet Seat (RTS), 300 lb max (E0244)
* Raised Toilet Seat (RTS) with Arms, 300 lb max (E0244)
* Shower Chair/Bath Stool, 300 lb max (E0245)
* Toilet Safety Frame (Versa Frame), 250 lb max (E0243)
* Grab Bar (E0241)
* Tub Transfer Bench (TTB) 300 lb max (E0247)
 | Bariatric Equipment* Commode, Bedside, HD, 450 lb max (E0168)

*Note: The following items are generally not covered by insurance** Commode, Drop Arm, HD 650 lb max
* Transfer Tub Bench (TTB), 500 lb max (E0248)
* Shower Chair /Bath Stool, 500 lb max (E0245)
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COMMODE MEDICAL NECESSITY INFORMATION: Must be supported in the medical records, if applicable

1. Is the patient confined to a single room? \_\_\_\_\_YES\_\_\_\_NO
2. Is the patient confined to one level of the home environment and there is no toilet on that level? \_\_\_\_\_YES\_\_\_\_NO
3. Is the patient confined to the home and there are no toilet facilities in the home?

 \_\_\_\_\_YES\_\_\_\_NO

| 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 Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_NPI:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Provider Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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