

CERTIFICATE OF MEDICAL NECESSITY

SEAT LIFT MECHANISM		
SECTION A Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___		
PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER (____)____-____-____ HICN _____	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER PROFESSIONAL REHAB SERVICES 28 SPENCERPORT ROAD ROCHESTER, NY 14606 (585) 429-6486 NSC # 4037840001	
PLACE OF SERVICE _____ NAME and ADDRESS of FACILITY if applicable (See Reverse)	HCPCS CODE _____ _____ _____	PT DOB ___/___/___; Sex ___ (M/F); HT ___ (in.); WT ___ (lbs.) PHYSICIAN NAME, ADDRESS (Printed or Typed) PHYSICIAN'S UPIN: _____ PHYSICIAN'S TELEPHONE #: (____)____-____-____
SECTION B Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.		
EST. LENGTH OF NEED (# OF MONTHS): _____ 1-99 (99=LIFETIME) DIAGNOSIS CODES (ICD-9): _____		
ANSWERS	ANSWER QUESTIONS 1 -5 FOR SEAT LIFT MECHANISM (Circle Y for Yes, N for No, or D for Does Not Apply)	
Y N D	1. Does the patient have severe arthritis of the hip or knee?	
Y N D	2. Does the patient have a severe neuromuscular disease?	
Y N D	3. Is the patient completely incapable of standing up from a regular armchair or <u>any</u> chair in his/her home?	
Y N D	4. Once standing, does the patient have the ability to ambulate?	
Y N D	5. 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.	
NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print): NAME: _____ TITLE: _____ EMPLOYER: _____		
SECTION C Narrative Description Of Equipment And Cost		
(1) <u>Narrative</u> description of all items, accessories and options ordered; (2) Supplier's charge; and (3) Medicare Fee Schedule Allowance for <u>each</u> item, accessory, and option. (See <i>Instructions On Back</i>)		
SECTION D Physician Attestation and Signature/Date		
I certify that I am the physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.		
PHYSICIAN'S SIGNATURE _____ DATE ___/___/___ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)		