

Certificate of Medical Necessity Form



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Seat lift chair/patient lift and sit to stand/standing frame systems

Section 1

SECTION 1: CERTIFICATION DATE: INITIAL _____ / _____ / _____ REVISED _____ / _____ / _____

Patient Name _____
Printed or Typed

Address _____
Street

City State ZIP Code County

Telephone (_____) _____ - _____ ID# _____

Supplier Name _____
Printed or Typed

Address _____
Street

City State ZIP Code County

Telephone (_____) _____ - _____ NPI# _____

Physician Name _____
Printed or Typed

Address _____
Street

City State ZIP Code County

Telephone (_____) _____ - _____ NPI# _____

PT DOB ____/____/____ SEX _____ (M/F) HEIGHT _____ WEIGHT _____

Section 2

SECTION 2: MEDICAL NECESSITY INFORMATION (Physician if this section is blank please complete)

Estimated length of need (# of months): _____
1 through 99 (99 = lifetime)

Diagnosis codes (ICD-9): _____ - _____ /
_____ - _____ / _____ - _____ /
_____ - _____ / _____ - _____ /

For "sit to stand systems" how many hours per day will the patient be in the stander: _____

Comments: _____

Other complicating factors: _____

- YES NO Does the patient have severe arthritis of the hip or knee?
- YES NO Does the patient have a severe neuromuscular disease?
- YES NO Is the patient completely incapable of standing up from a regular chair in their home?
- YES NO Once standing does the patient have the ability to ambulate?
- YES NO Have all appropriate therapeutic modalities to enable the patient to transfer from a chair to a standing position (e.g., medication, physical therapy, etc.) been tried and failed (Please circle appropriate answer.) (By marking YES you are certifying that this is documented in the patient's medical records.)

Section 3

SECTION 3: PHYSICIAN ATTESTATION AND SIGNATURE/DATE

I certify that I am the physician identified in Section A of this form. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge. (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

Physician's Signature _____

Date _____ / _____ / _____