Certificate of Medical Necessity

Form for seat lift chair/patient lift and sit to stand/standing frame systems

BlueCross BlueShield of Kansas

Section 1A – Patient Information

CLEAR DATA

First Name | MI | Address

Last Name | Suffix | City

Phone Number | ID Number | State | ZIP Code | +4 | County

Date of Birth | Height | Weight

Section 1B – Supplier Information

Supplier Name | Address

Phone Number | NPI Number | City

State | ZIP Code | +4 | County

Section 1C – Physician Information

First Name | MI | Address

Last Name | Suffix | City

Phone Number | ID Number | State | ZIP Code | +4 | County

Section 2 – Medical Necessity Information

Note: Physician, if this section is blank, please complete.

Initial Certification Date | Revised Certification Date

Estimated length of need (number of months) _____
1 – 99 (99 = Lifetime)

Diagnosis codes (ICD-10) – separate with a comma:

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

Yes	No	
☐	☐	Does the patient have severe arthritis of the hip or knee?
☐	☐	Does the patient have a severe neuromuscular disease?
☐	☐	Is the patient completely incapable of standing up from a regular chair in his/her home?
☐	☐	Once standing, does the patient have the ability to ambulate?
☐	☐	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? (By marking Yes, you are certifying that this is documented in the patient's medical records.)

Please continue on the next page.

Section 2 – Medical Necessity Information (continued)

Comments:

Other complicating factors:

Section 3 – Physician Attestation and Signature

I certify that I am the physician identified in section 1C of this form. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge.

Your signature required

Physician's Signature (Signature and date stamps are not acceptable)

Date Signed