



Patient Lift Standard Written Order

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Patient Name: _____ Phone #: _____

Address: _____

Ins ID#: _____ Patient DOB: _____ Sex: ☐ Male ☐ Female

Refer to patient lift coverage criteria sheet for all required documentation.

PATIENT LIFT:

Date of Last Visit: _____

Diagnosis and Code: _____

Length of Need (# of months) _____ 1-99 (99=lifetime) Patient Height: _____ in. Weight: _____ lbs.

Standard Equipment

☐ Patient Life, Manual with Sling, 400 lb. max (E0630)

☐ Replacement Sling (E0621)

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's Signature: _____ Date: _____ NPI: _____

Providers Name: _____ Telephone: _____