PATIENT LIFT-ORDER FORM/RX

DATE OF ORDER: **Length of Need:_____**

PATIENT NAME: DOB:
ADDRESS: HT:_____ WT:_____
CITY: ZIP:
PHONE:

ICD 10 Code1_____ ICD 10 Code3_____
ICD 10 Code2_____ ICD 10 Code4_____

A patient lift is covered if transfer between bed and a chair, wheelchair, or commode is required and, without the use of a lift, the patient would be bed confined.

MEDICAL EQUIPMENT ORDER:

____Patient Lift, Hydraulic or Mechanical: E0630

____Hoyer Sling: E0621 (Circle One) - Full Body - Full Body with Commode Opening - Split leg

Insurance does not cover Electric Patient Lifts

For a lift to be covered, a signed and dated order must be received before a claim is submitted

Doctors Name: NPI:

Address:

Fax # Phone #

Doctors Signature _____ Date_____