Atlantic HEALTHCARE PRODUCTS
www.AtlanticHP.com/Rx

Lift Chair Mechanism Order

PATIENT INFORMATION

Patient:_____

DOB:_____

Order Date:_____

Patient Contact Number: _____

Patient Height: _____

Patient Weight: _____

DIAGNOSIS

❑ DX Code:_____

❑ Length of need: 99 or _____

Order Type

□ E0627 Electric Seat Lift Mechanism

PHYSICIAN INFORMATION

Practitioner's Name: _____

NPI: _____

Practitioner's Signature

Date

Note: *Fax the following items to 561-290-1434 and we will take care of the rest. 1) This completed order, 2) Completed CMN (attached), 3) Chart Notes from last office visit.*

West Palm Beach
6782 Forest Hill Blvd, West
Palm Beach, FL 33411
561-964-6767

Atlantic Healthcare Products
Medical Documentation Coordination
Phone: 561-290-1434
Fax: 561-290-1434

Boynton Beach
9832 S. Military Trail G1
Boynton Beach, FL 33411
561-733-2331

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved OMB
No. 0938-0679
Expires 02/2024

CERTIFICATE OF MEDICAL NECESSITY
CMS-849 — SEAT LIFT MECHANISMS

DME 07.03A

SECTION A: Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___ RECERTIFICATION___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and MEDICARE ID		SUPPLIER NAME, ADDRESS, TELEPHONE and NSC or NPI # Atlantic Healthcare Products Inc
(__ __ __) __ __ __ - __ __ __ __ Medicare ID _____		(__ __ __) __ __ __ - __ __ __ __ NSC or NPI #_____
PLACE OF SERVICE _____12___	Supply Item/Service Procedure Code(s):	PT DOB ____/____/____ Sex ____ (M/F) Ht. ____(in) Wt ____
NAME and ADDRESS of FACILITY *if applicable (see reverse)*	_____ _____ _____ _____	PHYSICIAN NAME, ADDRESS, TELEPHONE and UPIN or NPI # (__ __ __) __ __ __ - __ __ __ __ UPIN or NPI #_____

SECTION B: Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.

EST. LENGTH OF NEED (# OF MONTHS): __99__ 1-99 *(99=LIFETIME)* | DIAGNOSIS CODES: _____ _____ _____ _____

ANSWERS	ANSWER QUESTIONS 1-5 FOR SEAT LIFT MECHANISM (Check 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 any 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) Narrative description of all items, accessories and options ordered; (2) Supplier's charge; and (3) Medicare Fee Schedule Allowance for each item, accessory, and option. (see instructions on back)

1. E0627 - Seat Lift Mechanism	2. $ 307.69	3. $ 307.69
1. A0927 - Chair	2.	3. $ 0.00

SECTION D: PHYSICIAN Attestation and Signature/Date

I certify that I am the treating 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.