U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0679

CERTIFICATE OF MEDICAL NECESSITY

DMERC 07.02A

SEAT LIFT MECHANISM

SECTION A

Certification Type/Date: **INITIAL** ___/___/___ **REVISED** ___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER

(__ __ __) __ __ __ - __ __ __ __ HICN _____

SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER

Allstate Dme
4009 S. Closner
Edinburg,TX 785397279
(956-287-8584- __ __ __ __ NSC # 1982847992

PLACE OF SERVICE _____

NAME and ADDRESS of FACILITY if applicable (See Reverse)

HCPCS CODE

_____
_____
_____
_____

PT DOB ___/___/___; **Sex** ___ **(M/F)** ; **HT.**_____**(in.)** ; **WT.**_____**(lbs.)**

PHYSICIAN NAME, ADDRESS (Printed or Typed)

PHYSICIAN'S UPIN: _____

PHYSICIAN'S TELEPHONE #: (__ __ __**)** __ __ __**-** __ __ __ __

SECTION B

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

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

DIAGNOSIS CODES (ICD-9): _____ _____ _____ _____

ANSWERS	ANSWER QUESTIONS 1 -5 FOR SEAT LIFT MECHANISM (Circle **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 <u>any</u> 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) <u>Narrative</u> description of all items, accessories and options ordered; **(2)** Supplier's charge; and **(3)** Medicare Fee Schedule Allowance for <u>each</u> item, accessory, and option. *(See Instructions On Back)*

SECTION D

Physician Attestation and Signature/Date

I certify that I am the 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)

CMS 849 (4/96)