HOME MEDICAL INC

6550 N Hamlin Ave Lincolnwood, IL 60712 Phone: 847-480-9390 Fax: 847-480-9394

# BATHROOM SAFETY AIDS

## Physician Written order & Certificate of Medical Necessity

### Patient Information

Last Name: ______________________ First Name: ______________________

Date of Birth: ____________ Gender: ____________ Height: ____________ Weight: ____________

Address: ____________________________________________

Phone#: ______________________ Insurance #: ______________________

ß The following equipment is needed by the beneficiary as a medical necessity

- ☐ Shower chair (E0240)
- ☐ Raised toilet seat (E0244)
- ☐ Tub transfer bar attachment (E0246)
- ☐ Transfer bench (E0247)
- ☐ Transfer bench heavy duty (300lb) (E0248)

ICD-10 DX:

- ☐ M62.81– (Muscle weakness)
- ☐ Z91.81 (History of Falling)
- ☐ R26.81 (Unsteadiness on feet)
- ☐ Z74.09 (Reduced Mobility)

**Other Diagnosis (ICD-10):**______________________________________________

By signing below, I authorize the use of this document as a legal prescription, and certify that the above prescribed supply is medically necessary and reasonable, and this patient meets all requirements and medical necessity for above prescribed supply. Information provided is true and supported in the patient's Medical Record.

### Physician Information

Physician Name: ______________________ NPI Number: ______________________

Address: ____________________________________________

Phone: ______________________ Fax: ______________________

Physician Signature: ______________________ Date: ______________________