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Commode Physician Detailed Written Order/Certificate of Medical Necessity

Patient Name: Height: Weight:

Patient DOB: / /

Estimated Length of Need (99 = Lifetime): Diagnosis:

Date Last Seen: / /

Description: COMMODE 3-IN-1 ( up to 300 lbs) Code: E0163

(CHECK) appropriate answer(s):

- Yes No N/A Is the patient confined to one level of the home and there is no toilet on that level?
Yes No N/A Is the patient confined to the home and there are no toilet facilities in the home?
Yes No N/A Is the patient confined to a single room?

Description: COMMODE 3-IN-1 Drop Arm ( up to 300 lbs) Code: E0165

(CHECK) appropriate answer(s):

- Yes No N/A Is the patient confined to one level of the home and there is no toilet on that level?
Yes No N/A Is the patient confined to the home and there are no toilet facilities in the home?
Yes No N/A Is the patient confined to a single room?
Yes No N/A Are detachable arms needed to facilitate transfer of patient or body requiries extra width?

I, the undersigned, certify that the above prescribed equipment/supplies is medically necessary as part of my treatment for this patient. In my opinion, the equipment prescribed is reasonable and necessary for accepted standards of medical practice and treatment of this patient's condition and has not been prescribed as "convenience equipment."

Physician Name: Physician Signature:

NPI: Date: / /

Address:

Phone: