847-824-0500 * PULMONARY PROVIDERS GROUP, INC. * 847-824-0529 fax

CERTIFICATE OF MEDICAL NECESSITY

Bathroom Products Order Form

Referral Source:_____ Referral Source Phone:(_____)_____

PATIENT INFORMATION

Last Name:_____ First Name:_____

Address: _____

City:_____ State: Illinois Zip code:_____

Phone Number: (_____)_____

Sex: Female_____ Male_____ Birth Date:_____/_____/_____

Height:_____ Weight:_____

DIAGNOSIS INFORMATION

Primary :_____

Secondary:_____

INSURANCE INFORMATION

Medicare Number:___ NOT COVERED_____

Medicaid Recipient Number:_____

Managed Care Medicaid Name:_____ Policy:_____

PRODUCT(S) REQUESTED

[ ] Shower Chair: [ ] w/o Back [ ] w/Back [ ] Bariatric shower chair > 300lbs w/Back

[ ] Tub Transfer Bench (TTB) [ ] Tub Transfer Bench (TTB), (**Bariatric > 300lbs**)

[ ] Raised toilet Seat [ ] Toilet Safty rails [ ] Tub Grab Bars

Length of Need_____(1-99 months) 99= Lifetime

PHYICIAN INFORMATION

Name:_____

Address:_____

City:_____ State:_____ Zip code:_____

Phone Number:(_____)_____

NPI:_____

I, the undersigned, certify that the above prescribed Durable Medical Equipment/Supplies are medically necessary as a part of my treatment for this patient. In my opinion, the equipment/item(s) prescribed are reasonable and necessary for the accepted standards of medical practice and treatment in patient's condition.

Physician Signature:_____ Date:_____/_____/_____