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

CERTIFICATE OF MEDICAL NECESSITY

Commode 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:_____

Medicaid Recipient Number:_____

Managed Care Medicaid Name:_____ Policy#:_____

Private Insurance Name:_____ Policy#:_____

PRODUCT(S) REQUESTED

[ ] Drop Arm Commode [E0165] Length of Need:_____(1-99 Months) 99=Lifetime

[ ] Commode [E0163]

[ ] Commode Xtra Wide/Heavy Duty [E0168] Patient must weight >300lbs.

The patient's medical records must contain at least one of the following information: Please check all that apply

1)._____ The beneficiary is confined to a single room, or

2)._____ The beneficiary is confined to one level of the home environment and there is no toilet on that level, or

3)._____ The beneficiary is confined to the home and there are no toilet facilities in the home.

4)._____ (E0165) The detachable arms feature is necessary to facilitate transferring the beneficiary or if the beneficiary has a body configuration that requires extra width. If coverage criteria are not met payment will be denied as not reasonable and necessary.

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:_____/_____/_____