

Lift Chair Mechanism:
DME Medical Review Form

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|---|----------------------------|
| Quality and Utilization Improvement Dept. | Telephone # (952) 883-5741 |
| DME - Medical Policy | Fax # (952) 853-8714 |

To be completed by a Health Professional (MD, NP, etc), not Vendor

*Please answer ALL of the following questions. This information is **REQUIRED** in order to determine if member meets coverage criteria.*

| | | |
|---------------|----------------|-----------|
| Member Name: | Date of Birth: | Member #: |
| Completed by: | Phone # : | Fax #: |

MD ordering (*Print Name*): _____ Date Completed: _____

Phone number: _____ Fax number: _____

1. Diagnosis: _____
2. Will use of a lift chair prevent further deterioration of medical condition? Yes No
If yes, please explain _____
3. Will use of the lift chair support member's independence or continued ambulatory status? Yes No
If yes, please explain _____
4. Is member wheelchair confined?..... Yes No
5. Is member bed confined?..... Yes No
6. Is the device needed solely as a transfer aid? Yes No
7. Is the Member's current place of residence a SNF/TCU? Yes No

Additional information:

I confirm that the information above is correct.

HealthCare Provider Signature: _____ **Date:** _____