HealthPartners

Lift Chair Mechanism

DME Medical Review Form

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

Member name:	Date of birth:	Member #:
Completed by:	Phone #:	Fax #:

Ordering practitioner:	NPI #:
Clinic name:	Clinic NPI# or Fed tax ID#
Clinic phone #:	Clinic fax #:
Diagnosis:	ICD-9/10:

1. Does the member have arthritis of the hip or knee? ☐ Yes ☐ No

If yes, please explain

_____

_____

2. Does the member have a neuromuscular disease such as Parkinson's or muscular dystrophy or another medical condition that affects his or her strength or mobility? ☐ Yes ☐ No

If yes, please explain

_____

_____

3. Is member unable to stand up from a regular armchair at home? ☐ Yes ☐ No

4. Can the member ambulate independently or with a walker or cane once standing? ☐ Yes ☐ No

Additional information:

_____

_____

_____

_____

I confirm that the information above is correct.

Physician or Treating Practitioner Signature: **Date:**

Please fax this completed form to member's Durable Medical Equipment Vendor.
For questions, call (952) 883-6333

Please include fax cover sheet when submitting.