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, 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:

2. Is the member able to stand up from a regular armchair at home? ☐ Yes ☐ No

3. Once standing, does the member have the ability to ambulate independently or with a properly fitted walker or cane? ☐ Yes ☐ No

4. Is the Member's current place of residence a SNF/TCU? ☐ 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.