GRADY HEALTH SYSTEM
STATEMENT OF MEDICAL NECESSITY OF HOME MEDICAL EQUIPMENT
REHAB THERAPY

PATIENT NAME, ADDRESS	SUPPLIER NAME, ADDRESS & PIN
PHONE: ( )_____	
DOB: _____ INS#: _____	DATE ORDERED:
1.A DIAGNOSIS: INCLUDE ICD-9 or 10 & NARRATIVE _____ _____ _____ Location of Patient: ☐ Home ☐ Other _____	I.B. PROGNOSIS: Good____ Fair____ Poor____ I.C. LAST EXAMINED THIS PATIENT ON:_____ I.D. ESTIMATED LENGTH OF NEED: ☐ LIFETIME OR ☐ _____ NUMBER OF MONTHS

2.A. IF EQUIPMENT IS:	HICPT	ANSWER QUESTIONS NUMBERED:
☐ CANE	E0100	1
☐ QUAD CANE	E0105	1
☐ WALKER	E0135	1,2
☐ WALKER WITH WHEELS	E0143	1,2,11
☐ SEAT FOR WALKER	E0156	1,2,11
☐ HEMI-WALKER	E0135	1,2
☐ CRUTCHES	E0116	1
☐ BEDSIDE COMMODE	E0163	3,4
☐ RAISED TOILET SEAT (M)	E0244	
☐ PATIENT LIFT	E0630	5,6,7
☐ TRAPEZE ATTACHMENT	E0910	8,9
☐ HOYER LIFT	E0630	8,9,10
☐ TRANSFER TUB BENCH (M)	E0246	12
☐ TUB BENCH (M)	E0245	13
☐ TRANSFER BOARD	E0972	
☐ OTHER _____		**(M)= Requires Medicaid**

2.B. Answer all questions applicable to equipment indicated above:

☐ YES ☐ NO 1. Ambulatory with impaired ambulation?
☐ YES ☐ NO 2. Need for greater stability and security than provided by a cane or crutch?
☐ YES ☐ NO 3. Patient room confined?
☐ YES ☐ NO 4. Patient confined to area without a bathroom?
☐ YES ☐ NO 5. Transfer of patient between bed and a chair, wheelchair, or commode requires more than one person?
☐ YES ☐ NO 6. Without use of lift, the patient would be bed confined?
☐ YES ☐ NO 7. Patient requires periodic movement to arrest or retard deterioration of condition?
☐ YES ☐ NO 8. Does patient need to get up due to respiratory condition? Or immediate change in body position.
☐ YES ☐ NO 9. Patient needs equipment to get in or out of bed or to assist in transfer from bed to wheelchair?
☐ YES ☐ NO 10. Patient does not own or rent a hospital bed.
☐ YES ☐ NO 11. Unable to use standard walker.
☐ YES ☐ NO 12. Needs assistance getting in and out of tub.
☐ YES ☐ NO 13. Needs support while taking bath.

I certify I certify the medical necessity of those items for this patient. Attending physician please sign below.

_____ NPI: _____
Physician Name Printed **(Must Be Pecos Enrolled)**

Address _____
All

_____
Physician Signature Date

Phone: _____

_____
Patient Signature (If Delivered at Facility) Date

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