GRADY HEALTH SYSTEM
STATEMENT OF MEDICAL NECESSITY OF HOME MEDICAL EQUIPMENT

PATIENT NAME, ADDRESS & HICN	SUPPLIER NAME, ADDRESS & PIN PROFESSIONAL MEDICAL HOME HEALTHCARE 4859C MEMORIAL DRIVE STONE MOUNTIAN, GA 30083 404-292-9190 PHONE 404-508-9225 FAX HOME HEALTH DEPT 404-616-2512 FAX 404-616-8908
☐ INITIAL ☐ RENEWAL ☐ REVISED	DATE ORDERED:
1.A DIAGNOSIS: INCLUDE ICD-9 AND NARRATIVE Location of Patient: ☐ Home ☐ Hospital ☐ Nursing 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
☐ ROLLATOR WALKER (WALKER WITH WHEELS)	E0143	1,2,11
☐ HEMI-WALKER		1,2
☐ CRUTCH (FOREARM)	E0114 (E0111)	1
☐ BEDSIDE COMMODE	E0163	3,4
☐ RAISED TOILET SEAT (M)	E0244	
☐ PATIENT LIFT	E0630	5,6,7
☐ CPAP MASK, TUBING, HEAD GEAR	A7034, A7037, A7035, A7030	
☐ TRACHEOSTOMY SUPPLIES		
☐ TRAPEZE ATTACHMENT	E0910	8,9
☐ HOYER LIFT	E0630	8,9,10
☐ TRANSFER TUB BENCH (M)	E0246	12
☐ TUB BENCH (M)	E0245	13
☐ TRANSFER BOARD	E0705	
☐ 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 change body positions for other medical reasons?
☐ 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.

_____
Physician Name Printed

_____
Physician Signature

NPI: _____
Address _____
_____
Phone: _____

6-11MEQ-(V1)

1/12.