**DME Medical Review Form**

# Lift Chair Mechanism

| | |
|---|---|
| Quality and Utilization Improvement Dept. | Telephone # 1-(888)-467-0774 |
| 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 whether coverage criteria are met.

| | | |
|---|---|---|
| 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:** _____

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