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www.northeastmedicalproducts.com
An Innova Medical Group Company

COMMODE PRESCRIPTION FORM

Patient Name _____ Phone _____

Address _____

Email _____

DOB _____ Height _____ Weight _____

Diagnosis codes _____ Length of Need _____

Alternate Contact Name _____ Relationship _____ Phone _____

Equipment:

_____ E0163 Commode

_____ E0165 Drop Arm Commode

_____ E0168 Bariatric Commode

Coverage Questions:

Y N Is there a bathroom in the home?

Y N Is the patient confined to one level of the home that has no bathroom?

Y N Is the patient confined to one room in the home?

Y N Does the patient require drop arms to facilitate transfer to commode?

Y N Does the patient weigh more than 300 lbs?

PLEASE SUPPLY A COPY OF THE NOTES FROM THE FACE-TO-FACE VISIT

(ALL CLINICAL NOTES MUST BE EITHER ELECTRONICALLY SIGNED OR HAVE A WET SIGNATURE)

Physician Name _____ NPI _____

Address _____

Phone _____ Fax _____

_____ _____

Physician Signature Date