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An Innova Medical Group Company

PATIENT LIFT PRESCRIPTION FORM

Patient Name _____ Phone _____

Address _____

Email _____

Diagnosis Codes _____ Length of Need _____

DOB _____ Height _____ Weight _____

Alternate Contact Name _____ Relationship _____ Phone _____

Equipment Ordered:

____ E0630 Patient lift, hydraulic or mechanical, includes any seat, sling, straps or pads

Sling Type (E0621):

____ Full Body with Commode Opening
____ Mesh ____ Polyester

____ Full Body without Commode Opening
____ Mesh ____ Polyester

____ Divided Leg (U-Sling) Padded

Coverage Questions:

Y N Does the patient need the lift in order to be transferred between bed and a chair, wheelchair, or commode?

Y N Without the use of a lift, would the patient be bed confined?

Y N Is there a caregiver in the house who can oversee and assist with transfers?

Physician Name _____ NPI _____

Address _____

Phone _____ Fax _____

_____ _____
Physician Signature Date