

Certificate of Medical Necessity (CMN) for Seat Lift Mechanism

Date: ____/____/____ **Requesting Provider:** _____

Pt. Name: _____ **I.D. Number:** _____

1. Does the patient have severe arthritis of the hip or knee?	Y	N	D
2. Does the patient have a severe neuromuscular disease? If Yes, Diagnosis: _____	Y	N	D
3. Is the patient completely incapable of standing up from a regular armchair or any chair in his/her home?	Y	N	D
4. Once standing, does the patient have the ability to ambulate?	Y	N	D
5. Have all appropriate therapeutic modalities to enable the patient to transfer from a chair to a standing position (e.g., medication, physical therapy) been tried and failed, and have been documented in the patient's medical records?	Y	N	D

Additional Clinical Rationale (Print):

Contact Name: _____ **Phone :** _____

Physician Signature (Stamps are not acceptable) **Date**

Contact Name: _____ **Phone :** _____

Physician Signature (Stamps are not acceptable) **Date**

Key - (Y)es, (N)o, (D)oes not apply

Requested Information:

1. Typed office note with pertinent information.