Medical Management & Policy
Fax Number: 412-544-2921

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**

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

Requested Information:
1. Typed office note with pertinent information.

Rev. 06/28/2011