DR.

Ph: _____ ADDRESS:
Fax: _____
NPI: _____

Patient Name: _____ **Weight:** _____ **Height:** _____

DOB:_____ **AGE:** _____

Address:

3-in-1 BEDSIDE COMMODE:

A commode is covered when the beneficiary is physically incapable of utilizing regular toilet facilities. This would occur in the following situations:

☐ – The beneficiary is confined to a single room.

☐ – The beneficiary is confined to one level of the home environment and there is no toilet on that level.

☐ – The beneficiary is confined to the home and there are no toilet facilities in the home.

(PLEASE CHECK ALL THAT APPLY)

DX:_____

_____

_____

ICD – 9 _____

I, undersigned, certify that the above prescribed equipment is medically necessary for this patient to achieve one or more MRADL's in the home. In my opinion, this equipment and accessories are both reasonable and necessary to accepted standards of medical practice in treatment of this patient's condition and are not prescribed as convenience supplies. By signing this form, I am confirming that the above information is accurate.

Physician signature _____ Date _____