HANDI MEDICAL SUPPLY

Standard Written Order: Patient Lift

Prescriber Information

Clinic/Location Name:
Prescriber Name:
Prescriber Address:
Prescriber City State Zip:
Prescriber Phone:
Prescriber Fax:
Prescriber NPI:

Patient Information

Patient Name:
Patient Address:
Patient City State Zip:
Phone:
DOB:
Primary Insurance:
Handi Customer Number:

Diagnosis (ICD-10)

Height: Weight:

HCPC	Description	Dispensing Qty
E0630	Patient Lift	1 Each per 5 Years
E0621	Patient Lift Sling	1 Each per 1 Year

Select one style:

☐ Standard Patient Lift (Hoyer Style)
☐ Sit to Stand Patient Lift (Get U Up style)

1. **Ordered Date:** _____
2. **Length of Need:** _____

Leaving blank presumes Lifetime (99 months)

3. **Please attach medical records supporting necessity of the above ordered item(s).**
4. **Please select Yes or No**

☐ **YES** ☐ **NO** Does the patient require the assistance of another person in order to transfer between wheelchair, bed, commode, or another surface in the home?

☐ **YES** ☐ **NO** Without the use of the above listed patient lift, would the patient be bed confined?

☐ **YES** ☐ **NO** Is the recipient unable to be transferred without a lift due to the patient medical condition or caregiver limitations?

☐ **YES** ☐ **NO** Will the lift fit into all necessary areas in the patient's home?

☐ **YES** ☐ **NO** If requesting a Get U Up (sit to stand style) Lift: Can the patient bear at least 80% of their weight?

5. _____ _____
Physician/NP/PA/Medical Practitioner Signature Date

: Signer must match Prescriber Information at the top of this form, or be updated below

Print New Prescriber Name: _____ NPI: _____

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