Form Approved
OMB No. 0938-0679

CERTIFICATE OF MEDICAL NECESSITY
CMS-849 — SEAT LIFT MECHANISMS

DME 07.03A

SECTIONA Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___ RECERTIFICATION___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER (__ __ __) __ __ __ - __ __ __ __ HICN ____________		SUPPLIER NAME, ADDRESS, TELEPHONE and NSC or applicable NPI NUMBER/LEGACY NUMBER (__ __ __) __ __ __ - __ __ __ __ NSC or NPI #____________
PLACE OF SERVICE____________	HCPCS CODE	PTDOB ___/___/___ Sex ___ (M/F) Ht. ___(in) Wt ___(lbs.)
NAME and ADDRESS of FACILITY if applicable (see reverse)	________ ________ ________ ________	PHYSICIAN NAME, ADDRESS, TELEPHONE and applicable NPI NUMBER or UPIN (__ __ __) __ __ __ - __ __ __ __ UPIN or NPI #____________

SECTION B Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.

EST. LENGTH OF NEED (# OF MONTHS): ______ 1-99 (99=LIFETIME) | DIAGNOSIS CODES (ICD-9): ______ ______ ______ ______

ANSWERSANSWER	QUESTIONS 1-5 FOR SEAT LIFTMECHANISM (Circle Y for Yes, N for No, or D for Does Not Apply)
Y N	? D
Y N	? D
Y N	? D
Y N	, does the patiDnt 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 (, medication, physical therapy) been tried and failed? If YES, this is documented in the patient's medical records.

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):
NAME: ______________________________TITLE: ________________EMPLOYER:________________

SECTION CNarrative Description of Equipment and Cost

(1) Narrative description of all items, accessories and options ordered; (2) Supplier's charge; and (3) Medicare Fee Schedule Allowance for each item, accessory, and option. (see instructions on back)

SECTION D PHYSICIAN Attestation and Signature/Date

I certify that I am the treating physician identified in Section Aof this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE____________________________________ DATE ____/____/____