CERTIFICATE OF MEDICAL NECESSITY CMS-849 — SEAT LIFT MECHANISMS

SECTION A 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 (818) 845-7488 Aamcare Electropedic 907 Hollywood Way, Burbank CA 91505 NPI #0801270001
PLACE OF SERVICE_____	HCPCS CODE	PT DOB ____/____/____ 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): _____ _____ _____ _____

ANSWERS	ANSWER QUESTIONS 1-5 FOR SEAT LIFT MECHANISM (Circle Y for Yes, N for No, or D for Does Not Apply)
Y N D	1. Does the patient have severe arthritis of the hip or knee?
Y N D	2. Does the patient have a severe neuromuscular disease?
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? 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 C Narrative 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)

A. Seat Lift Chair

B. $

C. EO627NU

SECTION D PHYSICIAN Attestation and Signature/Date

I certify that I am the treating physician identified in Section A of 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 _____/_____/_____ **Signature and Date Stamps Are Not Acceptable.**

INSTRUCTIONS FOR COMPLETING THE CERTIFICATE OF MEDICAL NECESSITY

FOR SEAT LIFT MECHANISMS (CMS-849) SECTION A: **(May be completed by the supplier)**

CERTIFICATION TYPE/DATE: If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked "INITIAL," and indicate the recertification date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL," and indicate the recertification date in the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date.

PATIENT INFORMATION: Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on his/her Medicare card and on the claim form.

SUPPLIER INFORMATION: Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC) or applicable National Provider Identifier (NPI). If using the NPI Number, indicate this by using the qualifier XX followed by the 10-digit number.
If using a legacy number, e.g. NSC number, use the qualifier 1C followed by the 10-digit number,

PLACE OF SERVICE: Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.

FACILITY NAME: If the place of service is a facility, indicate the name and complete address of the facility.

HCPCS CODES: List all HCPCS procedure codes for items ordered. Procedure codes that do not require certification should not be listed on the CMN.

PATIENT DOB, HEIGHT, WEIGHT AND SEX: Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested.

PHYSICIAN NAME, ADDRESS: Indicate the PHYSICIAN'S name and complete mailing address.

PHYSICIAN INFORMATION: Accurately indicate the treating physician's Unique Physician Identification Number (UPIN) or applicable National Provider Identifier (NPI). If using the NPI Number, indicate this by using the qualifier XX followed by the 10-digit number. If using UPIN number, use the qualifier 1G followed by the 6-digit number. (For example. 1Gxxxxxx)

PHYSICIAN'S TELEPHONE NO: Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed.

SECTION B: **(May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a Physician employee, it must be reviewed, and the CMN signed (in Section D) by the treating practitioner.)**

EST. LENGTH OF NEED: Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the patient will require the item for the duration of his/her life, then enter "99".

DIAGNOSIS CODES: In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 4 codes).

QUESTION SECTION: This section is used to gather clinical information to help Medicare determine the medical necessity for the item(s) being ordered. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, or "D" for does not apply.

NAME OF PERSON ANSWERING SECTION B QUESTIONS: If a clinical professional other than the treating physician (e.g., home health nurse, physical therapist, dietician) or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicated. If the physician is answering the questions, this space may be left blank.

SECTION C: **(To be completed by the supplier)**

NARRATIVE DESCRIPTION OF EQUIPMENT & COST: Supplier gives (1) a narrative description of the item(s) ordered, as well as all options, accessories, supplies and drugs; (2) the supplier's charge for each item(s), options, accessories, supplies and drugs; and (3) the Medicare fee schedule allowance for each item(s), options, accessories, supplies and drugs, if applicable.

SECTION D: **(To be completed by the physician)**

PHYSICIAN ATTESTATION: The physician's signature certifies (1) the CMN which he/she is reviewing includes Sections A, B, C and D; (2) the answers in Section B are correct; and (3) the self-identifying information in Section A is correct.

PHYSICIAN SIGNATURE AND DATE: After completion and/or review by the physician of Sections A, B and C, the physician's must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient.