DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0679

CERTIFICATE OF MEDICAL NECESSITY
CMS-849 -- SEAT LIFT MECHANISMS

DME 07.03A

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

NATIONAL MEDICAL SUPPLY, INC.
8021 S. GRANT WAY
LITTLETON, CO 80122
(303) 777-1100 NSC or NPI # **1144358839**

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 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)

HCPCS CODE	DESCRIPTION	QUANTITY	SUPPLIERS CHARGE	MEDICARE ALLOWABLE
E0627	SEAT LIFT MECHANISM INCORPORATED INTO A COMBINATION	1	$330.00	$330.00

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 the charges for items ordered). Any statement on my letterhead 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: _____/_____/_____