Phone: 860-674-1601

Equipment Request Form

Fax: 860-218-9966

Commodes

(Standard, Heavy Duty, Drop Arm)

Per Medicare requirements, a **SIGNED PHYSICIAN'S ORDER is required PRIOR TO delivery**. Please answer all questions below and return to DME Living Well. In addition, please make sure a signed copy is kept in your patient's file.

Patient Full Name: _____ Date of Birth: _____/_____/_____

Address City/St/Zip: _____

Medicare#_____Other Insurance Type & #_____

Referring Facility:_____Contact Name:_____PH: _____

Deliver To: □ Facility □ Home Req Delivery Date: _____ Approx. Time: _____ Discharge Date: _____

A **Commode (E0163**) is covered when the patient is physically incapable of utilizing regular toilet facilities. This would occur in the following situations:

- O The patient is **confined to a single room**, **OR**
- O The patient is **confined to one level of the home** environment and there is **no toilet on that level, OR**
- O The patient is confined to the home and there are **no toilet facilities in the home**.

Please forward Chart Notes supporting the need for the commode bedside, based on the above information.

Height:_____ Weight:_____ Length of Need (Months) (99=Lifetime): _____

- O An **Extra Wide/Heavy Duty Commode (E0168)** is covered for a patient who **weighs 300 pounds or more**. If the patient weighs less than 300 pounds but the basic coverage criteria for a commode chair are met, payment will be based on the least costly medically appropriate alternative, E0163.
- O A **Mobile Commode Chair (E0164, E0166)** is **NOT** medically necessary. If basic coverage criteria for a commode chair are met, payment will be based on the least costly medically appropriate alternative stationary commode chair, E0163 or E0165, respectively.
- O A **Drop Arm Commode (E0165)** is covered if the detachable arms feature is necessary to facilitate **transferring** the patient **OR** if the patient has a **body configuration that requires extra width**. If coverage criteria are not met payment will be denied as not medically necessary.

Diagnosis (es) that qualify the need of item delivered: _____

Ordering Physician, PA, or Nurse Practitioner Name (Please Print): _____NPI_____

Ordering Physician, PA, or Nurse Practitioner Signature:_____Date: _____

Please Fax This Page with Patient Demographics to: 860-218-9966