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CONTINUUM CONNECT HOYER LIFT ORDER FORM

****Please attach face sheet w/ patient demographics & insurance info****

PATIENT INFORMATION

Patient Name: _____ DOB: ____/____/____ Gender: Male Female
Language Pref.: English Spanish Other: _____ Patient cannot accept deliveries on the following days?
Height: _____ Weight: _____ Mon Tues Wed Thurs Fri Sat

DIAGNOSIS

Primary Diagnosis ICD-10 Code: _____ <small>*Non-Specified Codes will not qualify for Primary Diagnosis</small>	Secondary Diagnosis ICD-10 Code: _____
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Please answer questions below

- Does the patient have physical limitations that would make them bed ridden without this equipment? Yes No
- Does the patient require two or more people for transfers? Yes No
- Is the caregiver capable of operating the Hoyer Lift? Yes No
- Is the patients home environment able to accommodate the Hoyer Lift? Yes No
- Is the Hoyer Lift being used to transfer the patient from a bed to a wheelchair? Yes No

Please include (or attach) any additional information or documentation demonstrating the need for this Hoyer Lift:

Order Date: ____/____/____ **Length of Need:** _____ months

REFERRAL INFORMATION **Ref #:** _____

Practice Name: _____ Fax: _____
Office Address: _____ Email: _____
Phone: _____ Preferred Method of Contact? Phone Fax Email
Contact Person: _____

Physician Name: _____ NPI#: _____ Phone: (____) _____ - _____ Ext. _____

Physician Signature: _____ Date: ____/____/____

I certify that the above products are medically necessary and that the information provided is accurate to the best of my knowledge. By signing below, I acknowledge that I have obtained the patient's authorization to release the above information and other medical information that may be disclosed. I certify that my decision to prescribe this recommended product was solely based on my determination of medical necessity set forth herein. This document may serve as a confirmation of a verbal order and is also recorded in the patient's record.

Assignment of Benefits: I request that payment of my insurance benefits be made to CHC Solutions, Inc., or any of its subsidiaries, for any supplies or services they provide me. I am responsible for any balance due that is not covered by my insurance. I understand any product received in my home cannot be returned if opened. By signing below, I authorize the distribution of my information to CHC Solutions, Inc., or any of its subsidiaries, which may be needed to determine benefits payable for these services or supplies. I authorize CHC Solutions, Inc., or any of its subsidiaries, to forward my medical records to the medical professionals in my care and/or make copies of said records.

Patient Signature: _____ Date: ____/____/____