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CHAD WOJNAR R.PH., PRESIDENT
JACK LOVELAND R. PH., VICE PRESIDENT

Physician's Order Form for Commode

Equipment Ordered: **Date Ordered:**

Patient Name **DOB:**

Patient Address:

Insurance ID #: _____ **Height:** _____ **Weight:** _____**lbs**

**** The physician must complete this information in order to comply with Medicare Guidelines ****

ICD- 10 Code(s): _____ **Length of Need:** _____

**** Coverage Criteria (Please check all that apply):**

- ☐ **1. The patient is confined to a single room,** or…
- ☐ **2. The patient is confined to one level of the home environment and there is no toilet on that level,** or…
- ☐ **3. The patient is confined to the home and there are no toilet facilities in the home.**

Physician Name:_____ **NPI #** _____

Physician's Address:_____

_____

I, the undersigned, certify the above prescribed equipment and/or supplies are medically necessary as part of my treatment for this patient. In my opinion, the equipment and/or supplies prescribed are both reasonable and necessary for accepted standards of medical practice and treatment of this patient's condition. Neither the equipment and/or supplies are being prescribed as "convenience equipment".

Physician's Signature :_____**Date** _____

LC