



Lift Chair Prescription

Mayo Clinic Store

Form content not retained in medical record.

Route to Mayo Clinic Store for electronic storage.

(complete fields or place patient label here)

Patient Name (First Middle Last)
Birth Date (mm-dd-yyyy)
Mayo Clinic or Store Account Number

External Form Users: Complete this document and fax to the Mayo Clinic Store.

Internal Epic Downtime Form Users: Complete this document and fax to the Mayo Clinic Store. Once Epic downtime processes are complete, reenter order into the EHR and send an Epic message to the Mayo Clinic Store's inbasket pool informing them that a duplicated order was created.

Required: Attach patient's current primary, secondary, and tertiary insurance providers and provider-signed clinical documentation verifying medical justification from face-to-face examination.

Medicare Requirements

A lift chair's seat lift mechanism (E0627) is covered by Medicare if the beneficiary meets criteria for a lift chair. Face-to-face notes must document all the criteria below.

1. Patient has severe arthritis of the hip or knee, or a severe neuromuscular disease; and
2. Patient can't stand up on their own from a regular chair; and
3. Once standing, patient can walk independently or with the aid of a walker or cane; and
4. Patient does not reside within a skilled nursing facility, hospice, or nursing home; and
5. The practitioner's record documents all appropriate therapeutic modalities (that is, medications or therapy) that have been tried and failed to enable the patient to transfer from a chair to standing position.

Order Information

Order Date (mm-dd-yyyy)	Start Date (mm-dd-yyyy)	Need Length <input type="checkbox"/> Lifetime <input type="checkbox"/> Other _____
Qualifying Diagnosis (ICD-10)		Patient Height (inches) Patient Weight (pounds)
Date of Face-to-Face Examination (mm-dd-yyyy)	Patient Phone	
Patient Address (Street, City, State, ZIP Code)		

Device and Accessories

<input type="checkbox"/> Electric seat lift mechanism (E0627) <input type="checkbox"/> Lift chair frame (E1399)
Accessories (select all that patient has a medical need for)
<input type="checkbox"/> Lumbar support. Supporting diagnosis _____
<input type="checkbox"/> Neck support. Supporting diagnosis _____
Special Instructions

Referring Provider Information and Signature

Facility	Phone	Fax
Provider Signature ▶	Date (mm-dd-yyyy)	
Provider Printed Name (First Middle Last)	National Provider Identifier	