Phone: 586-778-2500
**Fax: 866-565-5190**

Equipment Request Form

# 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 Renaissance Medical. 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 Ins 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:

- ❑ The patient is **confined to a single room**, **OR**
- ❑ The patient is **confined to one level of the home** environment and there is **no toilet on that level, OR**
- ❑ 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): _____**

- ❑ 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.
- ❑ 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.
- ❑ 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): _____

Ordering Physician, PA, or Nurse Practitioner Signature: _____ Date: _____/ _____/

NPI: _____

Please Fax This Page with Patient Demographics To: 1•866•565•5 190