APPENDIX R

CERTIFICATION FOR PATIENT LIFT

Alliant GMCF
PA/UM Department
PO Box 105329
Atlanta, GA 30346

Member Medicaid Number _____ Date of Birth _____
Member Full Name _____

Diagnosis_____ICD-9 Code_____

Condition or limitations that require lift_____

Percentage of paralysis: _____Area of body paralyzed_____

*PT/OT EVALUATION IS REQUIRED

Member's specific physical limitations (check appropriate boxes):

- ☐ Cannot stand or walk
- ☐ Bedbound
- ☐ Bed to wheelchair bound

Weight:* _____ Height: _____
If less than 100 pounds, why can't caregiver weight shift without lift?_____

Who is the member's primary caregiver? _____
What is the physical condition of the caregiver? _____
Is the patient's caregiver able to use a non-hydraulic lift? ☐ YES ☐ NO
If "no", why not?_____

How long will the member need the lift? _____ months
What is the member's prognosis? _____

Additional comments_____

I CERTIFY THAT THIS PATIENT LIFT IS MEDICALLY NECESSARY:

Physician Signature *_____ Date _____
Physician's Printed Name_____
Address_____
***Stamped signatures are not acceptable**