Certificate of Medical Necessity
Bath Chair

Section A Certification Type/Date Initial ____/____/___ Revised___/____/___

Patient Name:	Member ID #:
Address:	Ordering Physician:
Telephone:	Telephone:

Section B

Diagnosis(es)	
Answers	(Circle **Y** for Yes, **N** for No, or **D** for Does not Apply)
Y N D	Does the patient has an acute condition (neurologic, motor, metabolic)?
Y N D	Can patient transfer him or herself from bed to a chair?
Y N D	Is patient unable to bathe or shower without being seated?
Y N D	Is patient bedridden?
Y N D	Is patient homebound or from an "Hogar"?
Y N D	Does patient has impaired ambulation and requires assistance in bathing?

Please note that patient needs to be able to transfer him or herself from bed to chairand requires assistance.

Section C

Physician Comments:

Secction D Physician Attestation and Signature/ Date

I Certify the medical neccesity for the service requested and that the information above is true, accurate and complete, to the best of my knowledge.

Physicians Signature____

Date_____/_______/_______ Lic. #:____