TRIPLE-S ADVANTAGE

Certificate of Medical Necessity

Bath Chair

Section A: General Information — Certification: Initial: Revised:____/____/____

Patient Name:	Customer ID #:
Address:	Physician Name:
Telephone:	NPI:

Section B: Eligibility Criteria

Est. Length of need (# of months):	Diagnosis Codes:

Answers	(Circle **Y** for Yes, **N** for No, or **D** for Does not Apply)
Y N D	Does the patient have an acute condition (neurologic, motor, and metabolic)?
Y N D	Can patient transfer him or herself from bed to a chair?
Y N D	Is patient unable to bath or shower without being seated?
Y N D	Is patient bedridden?
Y N D	Is patient homebound or from a "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 chair and requires assistance.

Section C: Physician Comments:

Section D: Physician Attestation and Signature/Date

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

Physicians Signature_____

Date: _____/_____/_____ (Month / Day / Year) Lic. #:_____

Rev. 3/2015