181 Illinois Ave S
Mansfield OH 44905
P 800-797-5696 F 888-805-9060

Prescription/Certificate of Medical Necessity (CMN)

Patient Information:

Patient's First and Last Name:		Date of Birth:	
Patient's Address:			

Equipment Prescribed:

Description	HCPC Code
PediaLift Specialty Infant Access Device - Wheelchair accessible device for disabled parent.	E1399

*The above equipment will be: X Purchased ❑ Repaired

Patient Status:

Diagnosis & ICD-10 Codes:	

Physician/Physician Assistant (PA)/Nurse Practitioner (NP)/Clinical Nurse Specialist (CNS) Information:

I certify that the above named patient requires the use of the PediaLift Device and related components listed above. My prescription is based on the evaluation of the patient's physical needs made by a team led by a licensed physician.

PA/NP/CNS Signature: _____ Date: _____

PA/NP/CNS's Printed First & Last Name:	
National Provider Identifier (NPI)	

Physician Signature: _____ Date: _____

Physician's Printed First and Last Name:			
National Provider Identifier (NPI)			
Phone:		Address:	
Fax:			

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