Valley Mission Homecare Pharmacy
12509 E Mission, Ste 103
Spokane Valley, WA 99216
valleymissionrx.com
Phone (509) 928-6400 **Fax (509) 928-6441**

BEDSIDE COMMODE (3-IN-1 STYLE)

Eligibility Assessment & Order Guidance Tool

- **This guidance is based on requirements for traditional Medicare Beneficiaries. Although other insurers may have less or more stringent requirements -including potential need for prior authorization - CMS policies serve as the reference standard. For questions, please call Valley Mission Homecare Pharmacy† at (509) 928-6400.**

STEP 1: Verify the patient's medical condition meets Medicare coverage criteria – All below are REQUIRED and must be explicitly referenced in the clients chart record:

- **Patient has a Medical Condition impacting mobility and is physically incapable of using regular toilet facilities due to one or more of the following reasons:**
  - **The patient is confined to a single room in his or her home, or**
  - **The patient is confined to one level of the home and there is no toilet on that level, or**
  - **The patient is confined to a home that lacks toilet facilities.**
- **Patient has been evaluated face-to-face for MRADL-related medical concerns within the past 6 months and has a care plan for ongoing evaluation at least every 6 months**
- ***For EXTRA-WIDE/HEAVY-DUTY commode*: The patient weighs 300 pounds or more**
- ***For REMOVABLE ARM/DROP ARM commode: A* detachable arms feature is necessary to facilitate transferring the patient or the patient has a body configuration that requires extra width.**

STEP 2: Complete all sections of the Bedside Commode Detailed Written Order (see page 2)

STEP 3: Fax the following documents to (509) 928-6441:

1. **The most recent face-to-face visit summary pertaining to mobility -related medical assessment. This must include documentation of required qualifications outlined in STEP 1 above.**
2. **Demographic face-sheet for the patient.**

† ***Valley Mission Homecare Pharmacy specializes in the provision of Durable Medical Equipment (DME) and Supplies to Medicare beneficiaries. Information provided here is intended solely to facilitate communication between the Ordering Provider and the DME Supplier to help ensure medical criteria are sufficient for presumptive coverage. This does NOT in any manner replace formal guidance located in the relevant Local Coverage Determination (LCD) specified by the Medicare Administrative Contractor.***

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Detailed Written Order

Patient Information

Last Name	First Name	Middle Name	Date of Birth

Physical Address	City	State	Zip Code

Billing Address (if different)	City	State	Zip Code

Phone	Alternate Phone

Prescriber Information

Last Name	First Name	Credential Type	NPI

Practice Location Address	City	State	Zip Code	Tax ID

Practice Location Phone	Practice Location Fax	Supervising Provider Name and NPI if applicable

Order Detail

Rx Bedside Commode (3-in-1 style)

Length of Need

Diagnosis (ICD-10) – list all codes pertinent to mobility impairment

Patient Height	Patient Weight

Additional requirments/instruction (e.g., Extra-wide/Heavy Duty commode and/or Removable Arm/Drop Arm commode)

I certify that I am the ordering prescriber specified above and hereby attest that information on this page is true, accurate and complete to the best of my knowledge and that the patient has suitable medical criteria documented in his/her patient record indicating medical necessity for the items listed above. I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil or criminal liability. The patient (and his/her caregivers, when applicable) is capable of using this equipment and has successfully completed or will be trained on the proper use of the products prescribed on this order.

Prescriber Signature	Date