

New Mexico Medicaid Utilization Review

P.O. Box 27950 Albuquerque, NM 87125-7950

Medical Justification for a Bedside Commode

Date: _____

Recipient: _____

Medicaid #: _____

Circle One

- | | | |
|---|---|---|
| 1. Is the patient confined to bed or to a room? If yes, please provide the diagnosis. | Y | N |
| _____ | | |
| 2. Are toilet facilities in the home located on the patient's floor level? | Y | N |
| 3. Please specify physical limitations that inhibit the patient from using the home facility. | | |
| _____ | | |
| _____ | | |
| _____ | | |
| _____ | | |
| _____ | | |
| _____ | | |

M.D. Signature: _____