

Certificate of Medical Necessity Form



Hospital Bed

SECTION 1: CERTIFICATION DATE: INITIAL _____ / _____ / _____ REVISED _____ / _____ / _____

Patient Name _____
Printed or Typed

Address _____
Street

City State ZIP Code County

Telephone (_____) _____ - _____ ID# _____

Supplier Name _____
Printed or Typed

Address _____
Street

City State ZIP Code County

Telephone (_____) _____ - _____ NPI# _____

Physician Name _____
Printed or Typed

Address _____
Street

City State ZIP Code County

Telephone (_____) _____ - _____ NPI# _____

PT DOB ____/____/____ SEX _____ (M/F) HEIGHT _____ WEIGHT _____

SECTION 2: MEDICAL NECESSITY INFORMATION (Physician if this section is blank please complete)

Estimated length of need (# of months): _____
1 through 99 (99 = lifetime)

Diagnosis codes (ICD-9): _____ - _____ /
_____ - _____ / _____ - _____ /
_____ - _____ / _____ - _____ /

- YES NO Does the patient require positioning of the body in ways not feasible with an ordinary bed due to a medical condition, which is expected to last at least one month?
- YES NO Does the patient require, for the alleviation of pain, positioning of the body in ways not feasible with an ordinary bed?
- YES NO Does the patient require the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease, or aspiration?
- YES NO Does the patient require traction, which can only be attached to a hospital bed?
- YES NO Does the patient require a bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair or standing position?
- YES NO Does the patient require frequent changes in body position and/or have an immediate need for a change in body position?
Please indicate time spent in bed during day (give time in approximate hours): _____.
- YES NO Is patient bed confined?
- YES NO Is patient room confined?
- YES NO Is patient 1st floor confined?

SECTION 3: PHYSICIAN ATTESTATION AND SIGNATURE/DATE

I certify that I am the physician identified in Section A of this form. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge. (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

Physician's Signature _____

Date _____ / _____ / _____

Section 1

Section 2

Section 3