

Certificate of Medical Necessity Form



Support Surfaces (Mattresses and Pads)

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 1

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 Is the patient highly susceptible to decubitus ulcers?
- YES NO Are you supervising the use of the device?
- YES NO Does the patient have co-existing pulmonary disease?
- YES NO Has a conservative treatment program been tried without success?
- YES NO Was a comprehensive assessment performed after failure of conservative treatment?
- YES NO Are open, moist dressings used for the treatment of the patient?
- YES NO Is there a trained full-time caregiver to assist the patient and manage all aspects involved with the use of the bed?
- YES NO Does the patient currently have decubitus ulcers?

	1. Ulcer #1	2. Ulcer #2	3. Ulcer #3	4. Ulcer #4
a. Stage	_____	_____	_____	_____
b. Length cm	_____	_____	_____	_____
c. Width cm	_____	_____	_____	_____

If the answer to question 8. Is YES please provide the stage and size of each pressure ulcer necessitating the use of the overlay, mattress or bed.

Improved Remained the Same Worsened

Over the past month, the patient's ulcer(s) has/have: _____

Section 2

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 3