

Certificate of Medical Necessity Form

Support Surfaces (Mattresses and Pads)



www.bcbsks.com

CERTIFICATION DATE: INITIAL _____ REVISED _____

Patient information:

First Name _____ Street Address _____
Last Name _____ City _____
Member Identification Number _____ State _____ ZIP Code _____ +4 _____ County _____ Phone Number _____

Supplier information:

Supplier Name _____ Street Address _____
NPI # _____ City _____
Phone Number _____ State _____ ZIP Code _____ +4 _____ County _____

Physician information:

Physician Name _____ Street Address _____
NPI # _____ City _____
PT DOB _____ Sex M F State _____ ZIP Code _____ +4 _____ County _____ Phone Number _____
PT Height _____ PT Weight _____

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): _____ - _____ / _____ - _____ / _____ - _____ / _____ - _____ /

Please indicate time spent in bed during the day (give time in percentage): _____

- 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?

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.

	Ulcer #1	Ulcer #2	Ulcer #3	Ulcer #4	Over the past month, the patient's ulcer(s) has/have:
a. Stage	_____	_____	_____	_____	<input type="checkbox"/> Improved <input type="checkbox"/> Remained the Same <input type="checkbox"/> Worsened
b. Length cm	_____	_____	_____	_____	
c. Width cm	_____	_____	_____	_____	

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 _____