

**CERTIFICATE OF MEDICAL NECESSITY  
HOSPITAL BEDS**

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| <b>SECTION A</b> Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___ RECERTIFICATION ___/___/___  |  |  |
| PATIENT NAME, ADDRESS, TELEPHONE and MEMBER NUMBER<br><br>( ___ ) ___ - ___ MEMBER # _____   |  | SUPPLIER NAME, ADDRESS, TELEPHONE and NSC OR applicable NPI NUMBER/LEGACY NUMBER<br><br>( ___ ) ___ - ___ NSC OR NPI # _____ |
| PLACE OF SERVICE _____   | HCPCS CODE _____   | PT DOB ___/___/___ Sex ___ (M/F) Ht. ___ (in) Wt. ___ (lbs.)   |
| NAME and ADDRESS of FACILITY If applicable<br>_____<br>_____<br>_____  | _____<br>_____<br>_____  | PHYSICIAN NAME, ADDRESS, TELEPHONE and applicable NPI/LEGACY NUMBER<br><br>( ___ ) ___ - ___ NSC OR NPI # _____              |
| <b>SECTION B</b> Information in this Section <b>May Not Be</b> Completed by the Supplier of the Items/Supplies.  |  |  |
| EST. LENGTH OF NEED (# OF MONTHS); _____ I-99 (99=LIFETIME)  |  | DIAGNOSIS CODES : _____  |
| ANSWERS  | Circle Y for Yes, N for No or D for Does Not Apply.  |  |
| Y N D  | 1. Does the patient's condition 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? |  |
| Y N D  | 2. Does the patient require, for the alleviation of pain, positioning of the body in ways not feasible with an ordinary bed?   |  |
| Y N D  | 3. 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?    |  |
| Y N D  | 4. Does the patient require special attachments which can only be attached to a hospital bed?  |  |
| Y N D  | 5. Does the patient's condition require a bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair, or standing position?                    |  |
| Y N D  | 6. Does the patient require frequent changes in body position and/or have an immediate need for a change in body position?   |  |
| <b>To expedite timely review, medical records to support the above statement must be submitted at the time of request.</b>   |  |  |
| Name of person answering section B questions, if other than the physician (PLEASE PRINT):<br><br>Name _____ Title _____ Employer _____   |  |  |
| <b>SECTION C Narrative Description of Equipment and Cost</b>   |  |  |
| (1) Narrative description of all items, accessories and options ordered; (2) Supplier's charge, and (3) Fee Schedule Allowance for each item, accessory, and option.<br><br><br><br><br><br><br><br><br><br>   |  |  |
| <b>SECTION D PHYSICIAN Attestation and Signature/Date</b>  |  |  |
| I certify that I am the treating physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed, and signed by me. I certify that the medical necessity information in Section B is true, accurate, and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.<br><br><br><br><br><br><br><br><br><br> |  |  |
| PHYSICIAN'S SIGNATURE _____  |  | DATE ___/___/___   |