

CERTIFICATE OF MEDICAL NECESSITY

HOSPITAL BEDS			
SECTION A Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___			
PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER (____) ____ - ____ HICN _____		SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER (____) ____ - ____ NSC # _____	
PLACE OF SERVICE _____ NAME and ADDRESS of FACILITY if applicable (See Reverse)	HCPCS CODE _____ _____ _____ _____	PT DOB ___/___/___; Sex ___ (M/F); HT. ___ (in.); WT. ___ (lbs.) PHYSICIAN NAME, ADDRESS (Printed or Typed) PHYSICIAN'S UPIN: _____ PHYSICIAN'S TELEPHONE #: (____) ____ - ____	
SECTION B Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.			
EST. LENGTH OF NEED (# OF MONTHS): _____ 1-99 (99=LIFETIME)		DIAGNOSIS CODES (ICD-9): _____	
ANSWERS	ANSWER QUESTIONS 1, AND 3-7 FOR HOSPITAL BEDS (Circle Y for Yes, N for No, or D for Does Not Apply)		
QUESTION 2 RESERVED FOR OTHER OR FUTURE USE.			
Y N D	1. 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?		
Y N D	3. Does the patient require, for the alleviation of pain, positioning of the body in ways not feasible with an ordinary bed?		
Y N D	4. Does the patient require the head of the bed to be elevated <u>more than 30 degrees</u> most of the time due to congestive heart failure, chronic pulmonary disease, or aspiration?		
Y N D	5. Does the patient require traction which can only be attached to a hospital bed?		
Y N D	6. Does the patient require a bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair, or standing position?		
Y N D	7. Does the patient require frequent changes in body position and/or have an immediate need for a change in body position?		
NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print): NAME: _____ TITLE: _____ EMPLOYER: _____			
SECTION C Narrative Description Of Equipment And Cost			
(1) <u>Narrative</u> description of all items, accessories and options ordered; (2) Supplier's charge; and (3) Medicare Fee Schedule Allowance for <u>each</u> item, accessory, and option. <i>(See Instructions On Back)</i>			
SECTION D Physician Attestation and Signature/Date			
I certify that I am the 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.			
PHYSICIAN'S SIGNATURE _____ DATE ___/___/___ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)			