℞ WRITTEN ORDER AND MEDICAL JUSTIFICATION
SEMI-ELECTRIC HOSPITAL BED

Date of Last Provider Visit_____

Supplier Name, Address, Telephone & NSC#:	**Patient Name, Address, Telephone & HIC#:**
PROCARE HOME MEDICAL **915 30th Avenue** **Fairbanks, AK 99701** **Phone: (907) 458-8912** **Fax: (907) 458-8914** **NSC#: 1267160002**	**( ) - HIC#:** **Patient DOB: / / Sex: (M/F)**

We have been asked to provide the following equipment to the patient named above. Please review and verify this information by completing any of the highlighted areas, and date and sign at the bottom. We suggest you keep a copy of this for your records.

SEMI-ELECTRIC HOSPITAL BED:

Date of Service: _____

Diagnosis and Code: _____

Length of Need (# of months)_____1-99 (99=life)

Patient Height: _____ft. in. Weight: _____ lbs.

Standard Equipment

- ☐ Hospital Bed, Semi-Electric, 350 lb max (E0260)
- ☐ Bed Side Rails, Half Length (E0305)
- ☐ Bed Side Rails, Full Length (E0310)

  Note: If full length rails are to be used in a facility (i.e. Assisted Living and/or Long Term Care) a restraint order is required to be on file prior to delivery.

- ☐ Bed Side Rails, Full Length are to be used as a patient restraint?

Bariatric Equipment

- ☐ Hospital Bed, Semi-Electric, HD, 600 lb max (E0301/E0303)
- ☐ Hospital Bed, Semi-Electric, HD, 750 lb max (E0302)
- ☐ Bed Side Rails, Half Length, HD (E0305)

MEDICAL NECESSITY INFORMATION:

REQUIRED CRITERIA

*Note patient must meet at least one of "A" **and** at least one of "B".*

CRITERIA "A"

Does the patient have a medical condition that requires positioning of the body in ways not feasible with an ordinary bed? *Note: Elevation of the head / upper body less than 30 degrees does not usually require the use of a hospital bed.*

☐ Y ☐ N

OR

Does the patient require positioning of the body in ways not feasible in an ordinary bed in order to alleviate pain?

☐ Y ☐ N

OR

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 problems with ASPIRATION? *Note: Pillows and wedges must have been considered and ruled out.*

☐ Y ☐ N

OR

Does the patient require the use of traction equipment that can only be attached to a hospital bed?

☐ Y ☐ N

CRITERIA "B"

Does the patient require frequent changes in body position?

☐ Y ☐ N

OR

Does the patient have an immediate need for a change in body position?

☐ Y ☐ N

PROVIDER CERTIFICATION:

I, the patient's treating provider, certify the medical necessity of these items for this patient and maintain medical records reflecting the medical justification and care provided.

_____

Provider's Signature Date

_____

Provider's Name

NPI: _____ Telephone: _____