HOSPITAL BED/TRAPEZE STANDARD WRITTEN ORDER

PROCARE HOME MEDICAL

Please fax to:
Anchorage (907) 274-0773
Fairbanks (907) 458-8914
Soldotna (907) 260-3757
Wasilla (907) 357-7883
or email to:
dme@procarehm.com

Patient Name, Address, Telephone & Insurance ID #:

Phone: _____ **Ins ID #:** _____

Patient DOB: _____ **Sex:** _____ **(M/F)**

Refer to Hospital Bed coverage criteria sheet for all required documentation.

HOSPITAL BED: ** all beds come standard w/half length rails. If full rails are needed please select under accessories*

Date of Last Visit: _____ Order Date: _____

Diagnosis and Code: _____

Length of Need (# of months)_____1-99 (99=life) Patient Height: _____ ft. in. Weight: _____ lbs.

Standard Equipment

☐ Semi-Electric Hospital Bed w/rails, 350lb max
- ☐ with mattress (E0260)
- ☐ without mattress (E0261)

Bariatric Equipment

☐ Heavy Duty Hospital Bed w/rails, 600lb max
- ☐ with mattress (E0303)
- ☐ without mattress (E0301)

☐ Extra HD Hospital Bed with rails and mattress, 750lb max (E0304)

Accessories/Replacement Items:

☐ Half Length, bedrails (E0305)
☐ Full Length, bedrails (E0310) **not available for HD or extra HD beds*
☐ Replacement Foam/Rubber Mattress (E0272)

Trapeze

☐ Trapeze Bar attached to Hospital Bed (E0910) up to 250lbs
☐ Trapeze Bar with Base (E0940) 250 lbs max
☐ Bariatric Trapeze Bar (E0912) 250-1000 lbs.

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: _____ NPI: _____

Provider's Name: _____ Telephone: _____