HAYAT HOME MEDICAL EQUIPMENT

SEMI-ELECTRIC HOSPITAL BED — PRESCRIPTION & MEDICAL NECESSITY FORM

3518 W 95th St, Evergreen Park, IL 60805 | Phone: 708-422-2300 | Fax: 708-422-5966

PATIENT / BENEFICIARY INFORMATION

Patient Name: _____	**DOB:** _____
Address: _____	**Phone:** _____
Medicare / Insurance ID: _____	**Member ID:** _____

DME ORDER

■ **SEMI-ELECTRIC HOSPITAL BED**	**Quantity:** _____
■ With Mattress ■ Without Mattress ■ Other: _____	**Length of Need:** _____

MEDICAL NECESSITY — REQUIRED QUALIFYING CRITERIA

The beneficiary must have a medical condition which requires positioning of the body in ways not feasible with an ordinary bed. Elevation of the head/upper body less than 30 degrees does not usually require the use of a hospital bed.

1. POSITIONING TO ALLEVIATE PAIN
The beneficiary requires positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain.

2. HEAD-OF-BED ELEVATION MORE THAN 30 DEGREES
The beneficiary requires the head of the bed to be elevated more than 30 degrees most of the time due to:
■ Congestive Heart Failure ■ Chronic Pulmonary Disease ■ Problems with Aspiration

3. TRACTION EQUIPMENT
The beneficiary requires traction equipment, which can only be attached to a hospital bed.

4. FREQUENT / IMMEDIATE POSITION CHANGES
The beneficiary requires frequent changes in body position and/or has an immediate need for a change in body position.

DIAGNOSIS / CLINICAL JUSTIFICATION

Primary Diagnosis: _____

Secondary Diagnosis(es): _____

Clinical justification explaining why an ordinary bed is not appropriate:

_____

_____

PRESCRIBER CERTIFICATION

I certify that I have evaluated this beneficiary and that the **semi-electric hospital bed** ordered above is medically necessary. The beneficiary meets at least one of the qualifying medical-necessity criteria selected above. The information provided is accurate and supported by the patient's medical record.

Prescribing Practitioner: _____

NPI: _____ **License #:** _____

Signature: _____ **Date:** _____

Practice Name: _____ **Phone:** _____

Practice Address: _____

DOCUMENTATION REQUEST: Please fax this completed prescription along with supporting office/clinical notes documenting the qualifying medical necessity to Hayat Home Medical Equipment.

FAX: 708-422-5966 **PHONE:** 708-422-2300 Payer-specific coverage and documentation requirements may apply.