



M E D I C A L C L E A R A N C E F O R M

H O S P I T A L A N D S P E C I A L T Y B E D S

Section A			
Certification Date: Initial: __/__/__		Revised: __/__/__	
Patient Name: _____		Supplier Name: _____	
Address: _____		Address: _____	
Phone Number: _____		Phone Number: _____	
RID Number: _____		Provider Number: _____	
Place of Service: _____ Name and address of facility (if applicable)	HCPCS Code: _____	PT DOB __/__/__/; Sex __ (M/F) HT _____ (IN); WT _____ (LBS)	
		Physician Name: Address:	
		Physician UPIN Number: _____	
		Physician Phone Number: () _____	
Section B			
<i>*Information in this section may not be completed by the supplier of the items or supplies</i>			
Estimated. length of need (number of months _____) Years _____ Lifetime _____		DX codes (ICD-9) _____	
Circle Y for Yes, N for No, or NA for Not Applicable for the following questions:			
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	NA
2. Does the patient require, for the relief of pain, positioning of the body in ways not feasible in an ordinary bed?	Y	N	NA
3. Does the patient require the head of the bed elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease or aspiration?	Y	N	NA
4. Does the patient require traction that can only be attached to a hospital bed?	Y	N	NA
5. 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	NA
6. Does the patient require frequent changes in body position and/or have an immediate need for a change in body position?	Y	N	NA

Section C

**Narrative description of equipment and cost*

(1) Narrative description of all items, accessories, and options ordered; and (2) supplier's charges:

Section D

**Complete this section if you are supplying or ordering a specialty bed. If supplying or providing a hospital bed, skip to Section E.*

What diagnosis qualifies this patient for a specialty bed? ICD-9 code:

Does this patient have seizures? Y N NA If yes, what type?

Date of last seizure: How often do seizures occur?

Has patient sustained injury related to seizure activity? Y N NA If yes, what type of injury?

List three safety factors that have been tried and why they failed?

Does this patient have a history of behavior problems that may result in injury, or a history of falls, respiratory problems, cardiac problems or gastrointestinal problems? Y N NA

If yes, document all that apply.

Section E: Physician Signature, Attestation, and Date

I certify that I am the physician listed in section A of this form. I have received sections A through E 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 falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

Physician's Signature:

Date: