

CERTIFICATE OF MEDICAL NECESSITY

HOSPITAL BEDS

SECTION A		Certification Type/Date: INITIAL <u> </u> / <u> </u> / <u> </u> REVISED <u> </u> / <u> </u> / <u> </u>
PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER (____) _____ HICN _____		SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER INDEPENDENT LIVING AIDS of GEORGIA 6002 Veterans Parkway Columbus, GA 31909 Fax: (706) 327-2099 (706) 327-5613 NSC # 1149340001
PLACE OF SERVICE _____ NAME and ADDRESS of FACILITY if applicable (See Reverse)	HCPCS CODE _____ _____ _____	PT DOB <u> </u> / <u> </u> / <u> </u> ; Sex <u> </u> (M/F); HT. <u> </u> (in.); WT. <u> </u> (lbs.) PHYSICIAN'S NAME, ADDRESS, TELEPHONE and UPIN NUMBER (____) _____ UPIN # _____

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) Narrative description of all items, accessories and options ordered; (2) Supplier's charge; and (3) Medicare Fee Schedule Allowance for each item, accessory, and option. (See Instructions On Back)

HCPCS CODE	QTY	DESCRIPTION OF EQUIPMENT	SUPPLIER'S CHARGE	MEDICARE ALLOWANCE
E0260 RR	1	FULL ELECTRIC HOSPITAL BED WITH MATTRESS & RAILS	\$ 250.00/Mo.	\$ 182.06/Mo.
E0296 RR	1	FULL ELECTRIC HOSPITAL BED WITHOUT MATTRESS	\$ 250.00/Mo.	\$ 133.19/Mo.

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)