Certification of Medicare Requirements for HOSPITAL BEDS

Patient Name:	
Patient Date of Birth:	
Address:	
Phone #:	
Requested DME:	
Patient Diagnosis (ICD-10):	
Prescribing Physician's Name:	
NPI / Licence number:	
Address:	

I have reviewed Medicare coverage criteria below and checked off the necessary criteria that would qualify the Patient for the requested DME Equipment:

Semi-Electric Hospital Beds

Medical records document one or more of the following criteria are met:

☐Beneficiary has 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; **or**

☐Beneficiary requires positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain; **or**

☐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, or problems with aspiration; **or**

☐Beneficiary requires traction equipment, which can only be attached to a hospital bed; **and**.

☐Beneficiary requires frequent changes in body position and/or has an immediate need for a change in position.

Heavy Duty Extra Wide Hospital Beds

☐Beneficiary has 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; **or**

☐Beneficiary requires positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain; **or**

☐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, or problems with aspiration; **or**

☐Beneficiary requires traction equipment, which can only be attached to a hospital bed; **and**.

☐Beneficiary's weight is more than 350 pounds but doesn't exceed 600 pounds.

_____	_____	_____
(Physician's Name and NPI/License Number)	(Physician's Signature)	(Date)