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HOSPITAL BED ORDER FORM

****Please attach face sheet w/ patient demographics & insurance info****

PATIENT INFORMATION

Patient Name: _____ DOB: ____/____/____ Gender: Male Female
 Language Pref.: English Spanish Other: _____ Patient cannot accept deliveries on the following days?
 Height: _____ Weight: _____ Mon Tues Wed Thurs Fri Sat

DIAGNOSIS

Primary Diagnosis ICD-10 Code: _____ <small>*Non-Specified Codes will not qualify for Primary Diagnosis</small>	Secondary Diagnosis ICD-10 Code: _____
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PRODUCTS

Equipment

- Manual Hospital Bed
- Semi-Electric Hospital Bed
- Full Electric Hospital Bed
- Heavy Duty Hospital Bed
- Other

Order Date: ____/____/____ Patients hip to hip measurement: _____
 Length of Need: _____ months

Questions to determine medical necessity and justify a Hospital Bed

Does this 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does the patient require, for the alleviation of pain, positioning of the body in ways not feasible in an ordinary bed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does the patient require 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 aspiration?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does the patient require traction that can be only be attached to a hospital bed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does the patient require a bed height different than a fixed height hospital bed to permit transfer to chair, wheelchair or standing position?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does the patient require frequent changes in body position and/or have an immediate need for a change in body?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is the patient able to independently operate the control of a semi-electric or full electric hospital bed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

REFERRAL INFORMATION

Ref #: _____

Practice Name: _____ Fax: _____
 Office Address: _____ Email: _____
 Phone: _____ Preferred Method of Contact? Phone Fax Email
 Contact Person: _____

Physician Name: _____ NPI#: _____ Phone: (____) _____ - _____ Ext. _____

Physician Signature: _____ Date: ____/____/____

I certify that the above products are medically necessary and that the information provided is accurate to the best of my knowledge. By signing below, I acknowledge that I have obtained the patient's authorization to release the above information and other medical information that may be disclosed. I certify that my decision to prescribe this recommended product was solely based on my determination of medical necessity set forth herein. This document may serve as a confirmation of a verbal order and is also recorded in the patient's record.

Assignment of Benefits: I request that payment of my insurance benefits be made to CHC Solutions, Inc., or any of its subsidiaries, for any supplies or services they provide me. I am responsible for any balance due that is not covered by my insurance. I understand any product received in my home cannot be returned if opened. By signing below, I authorize the distribution of my information to CHC Solutions, Inc., or any of its subsidiaries, which may be needed to determine benefits payable for these services or supplies. I authorize CHC Solutions, Inc., or any of its subsidiaries, to forward my medical records to the medical professionals in my care and/or make copies of said records.

Patient Signature: _____ Date: ____/____/____