

## CERTIFICATE OF MEDICAL NECESSITY

Highmark Blue Shield regulations require the following information be provided on claims for durable medical equipment, prosthetic devices, and orthotic devices. This form should be completed by the patient's physician and returned to us, accompanied by a Health Insurance Claim Form completed by the supplier.

Patient's Name: \_\_\_\_\_ Agreement Number: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Date this equipment prescribed: \_\_\_\_\_ Equipment will be needed for: \_\_\_\_\_ months

Prognosis: \_\_\_\_\_

This prescription applies to rental period from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_.

Please check the equipment you are prescribing and answer YES or NO to the corresponding question. Equipment with special attachments or features, or equipment not included below should be listed in the space provided.

	<u>YES</u>	<u>NO</u>	
<input type="checkbox"/> Hospital Bed (Answer A, B)	<input type="checkbox"/>	<input type="checkbox"/>	A. Is the patient bed confined?
<input type="checkbox"/> Electric Hospital Bed (Answer A, C, D)	<input type="checkbox"/>	<input type="checkbox"/>	B. Does the patient's condition require positioning of the body or attachments which would not be feasible with the use of an ordinary bed?
<input type="checkbox"/> Side Rails (Answer A, E)	<input type="checkbox"/>	<input type="checkbox"/>	C. Does the patient's condition require frequent and/or immediate changes in body position?
<input type="checkbox"/> Commode (Answer A, F, N)	<input type="checkbox"/>	<input type="checkbox"/>	D. Can the patient operate the controls himself?
<input type="checkbox"/> Trapeze Bar (Answer A, G, H)	<input type="checkbox"/>	<input type="checkbox"/>	E. Is the patient disoriented at any time?
<input type="checkbox"/> Alternating Pressure Pad (Answer I, J)	<input type="checkbox"/>	<input type="checkbox"/>	F. Is the patient room confined?
<input type="checkbox"/> Wheelchair (Answer K)	<input type="checkbox"/>	<input type="checkbox"/>	G. Is there a need for the patient to sit up due to respiratory conditions, etc.?
<input type="checkbox"/> Walker (Answer L, M)	<input type="checkbox"/>	<input type="checkbox"/>	H. Is there a medical need for a change in body position?
	<input type="checkbox"/>	<input type="checkbox"/>	I. Is the patient highly susceptible to decubitus ulcers?
	<input type="checkbox"/>	<input type="checkbox"/>	J. Are you supervising the use of pressure pad?
	<input type="checkbox"/>	<input type="checkbox"/>	K. Is the patient's condition such that the alternative would be bed or chair confinement?
	<input type="checkbox"/>	<input type="checkbox"/>	L. Does the patient's condition impair ambulation?
	<input type="checkbox"/>	<input type="checkbox"/>	M. Is the walker used for therapy?
	<input type="checkbox"/>	<input type="checkbox"/>	N. Is the patient confined to floor without bathroom facilities?

If ambulatory equipment such as a walker, cane or quad cane is being used with non-ambulatory equipment such as side rails, trapeze bar, etc., please explain why both are medically necessary.

\_\_\_\_\_

Items not included above and diagnosis or condition which warrants equipment.

\_\_\_\_\_

If equipment is not used in the patient's home, please indicate the name and address of the facility where the patient resides (print or type).

\_\_\_\_\_

Signature of the physician certifies that the above represents his judgment of the patient's need for the equipment.

**IMPORTANT:** This form must be signed and dated by the prescribing physician before the equipment may be considered for payment. (print or type).

Physician's Name: \_\_\_\_\_

Physician's Phone No.: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

Date: \_\_\_\_\_