Medical Management & Policy
Fax Number: 412-544-2921

Certificate of Medical Necessity (CMN) for Hospital Bed (Manual or Electric)

Date: ____/_____/_______ **Requesting Provider:** ______________________________

Pt. Name: _________________________________ **I.D. Number:** ____________________

Question			
1. Does the patient require positioning of the body in ways not feasible with an ordinary bed due to a medical condition? If Yes, what is (are) the diagnosis(es) for which this hospital bed is needed:	Y	N	D
2. Does the patient require, for the alleviation of pain, positioning of the body not feasible with an ordinary bed?	Y	N	D
3. Does the patient require upper body elevation more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease or aspiration risk?	Y	N	D
4. Have pillows and wedges been <u>tried and failed</u> to position patient?	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?	Y	N	D
8. Is the patient prone to contractures or respiratory infections?	Y	N	D
9. Does the patient have significant lower extremity pathology?	Y	N	D
10. Is the patient able to ambulate?	Y	N	D
11. Does the patient use a wheelchair?	Y	N	D
12. Is a physically competent caregiver/family member present for most of the day?	Y	N	D

Additional Clinical Rationale (Print):

Contact Name: _________________________________ **Phone :**________________

____ ____________________________

Physician Signature **(Stamps are not acceptable)** **Date**

Key - **(Y)**es, **(N)**o, **(D)**oes not apply

Requested Information:
1. Typed office note with pertinent information.