Ohio Department of Medicaid

CERTIFICATE OF MEDICAL NECESSITY: HOSPITAL BEDS AND BED ACCESSORIES

Identifying Information [This section may be completed by the provider.]

Individual	Prescriber	Provider
Name	Name	Name
Medicaid ID number	Medicaid provider number	Medicaid provider number
Date of birth	NPI	NPI
Height (in.) Weight (lbs.)	Telephone number	
Address*	*Note: Provision of or payment for equipment and supplies used by a resident of a long-term care facility (LTCF) is the responsibility of the LTCF.	

A HCPCS code corresponding to each hospital bed or bed accessory specified by the prescriber

Certification [This section may be transcribed by the provider.]

Mark all items that apply.

Diagnosis code(s)	Date of evaluation

Hospital Bed

☐ Rental for ___ months, from ___/___/_____ to ___/___/_____ ☐ Purchase

☐ The individual's condition (e.g., congestive heart failure, chronic obstructive pulmonary disease, problems with aspiration, disease aggravated by excessive body weight) necessitates elevation of the head or upper body to at least thirty degrees, and such elevation cannot be achieved with pillows or wedges in a standard bed.

☐ The individual uses or will use traction equipment that can be attached only to a hospital bed.

☐ The individual needs additional height or support for safe transfer to a chair, wheelchair, or standing position.

☐ The elevating functions of a hospital bed will facilitate frequent intervention by an assistant or caregiver to alleviate pain or prevent pressure sores.

Specification of additional feature

☐ Variable height ☐ Heavy duty construction

☐ Semi-electric operation ☐ Extra-heavy duty construction

Explanation of medical necessity of additional feature

☐ Additional information is attached.

Bed Accessory

☐ Rental for ___ months, from ___/___/_____ to ___/___/_____ ☐ Purchase

Specification of accessory

☐ Trapeze bar ☐ Patient lift

☐ Heavy duty trapeze bar ☐ Mattress, innerspring (replacement only)

Explanation of medical necessity of accessory

☐ Additional information is attached.

Attestation [This section must be completed by the prescriber.]

I hereby attest that the certification information above is true, correct, and complete.	
Signature of prescriber	Date of signature

False certification constitutes Medicaid fraud.