Oklahoma HealthCare Authority

CERTIFICATE OF MEDICAL NECESSITY
HOSPITAL BEDS

SECTION A **Certification Type/Date: INITIAL**___/____/____ **REVISED**____/____/___ **RECERTIFICATION**___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and MEMBER NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC OR applicable NPI NUMBER/LEGACY NUMBER
(__ __ __) __ __ __-__ __ __ __ MEMBER # _____	(__ __ __) __ __ __-__ __ __ __ NSC OR NPI # _____
PLACE OF SERVICE _____ HCPCS CODE	PT DOB ____/____/____ Sex _____ (M/F) Ht. ____(in) Wt. _____(lbs.)
NAME and ADDRESS of FACILITY *If applicable*	PHYSICIAN NAME, ADDRESS, TELEPHONE and applicable NPI/LEGACY NUMBER (__ __ __) __ __ __-__ __ __ __ NSC OR NPI # _____

SECTION B Information in this Section **May Not Be** Completed by the Supplier of the Items/Supplies.

EST. LENGTH OF NEED (# OF MONTHS); _____1-99 (99=LIFETIME) DIAGNOSIS CODES : _____ _____ _____ _____

ANSWERS	Circle Y for Yes, N for No or D for Does Not Apply.
Y N D	1. Does the patient's condition 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?
Y N D	2. Does the patient require, for the alleviation of pain, positioning of the body in ways not feasible with an ordinary bed?
Y N D	3. 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?
Y N D	4. Does the patient require special attachments which can only be attached to a hospital bed?
Y N D	5. Does the patient's condition require a bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair, or standing position?
Y N D	6. Does the patient require frequent changes in body position and/or have an immediate need for a change in body position?

To expedite timely review, medical records to support the above statement must be submitted at the time of request.

Name of person answering section B questions, if other than the physician (PLEASE PRINT):

Name_____Title_____Employer_____

SECTION C Narrative Description of Equipment and Cost

(1) Narrative description of all items, accessories and options ordered; (2) Supplier's charge, and (3) Fee Schedule Allowance for each item, accessory, and option.

SECTION D PHYSICIAN Attestation and Signature/Date

I certify that I am the treating physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed, and signed by me. I certify that the medical necessity information in Section B is true, accurate, and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE _____DATE _____/_____/_____