Hospital Bed

Written Order Prior to Delivery

Fort Medical Equipment LLC
306 N. Washington Ave.
Ft. Atkinson, WI. 53538-1741
Phone: 920-568-9860
Fax: 872-469-1691

Order Date: ____________________

Patient Name: ______________________________ Home Phone: ______________________

Date of Birth: ______________________________ Cell Phone: ______________________

Diagnosis: 1 ____________________ 2 ____________________ 3 ____________________

Duration: ☐ Lifetime (99) Other ________ months

Select a bed based on description and need.

Fixed Height Hospital Bed (E0250)	☐	Manually adjust head and leg elevation. Height adjustment is not needed.
Variable Height Hospital Bed (E0255)	☐	Manually adjust height, head, and leg elevation.
Semi-Electric Hospital Bed (E0260)	☐	Manually adjust height, electric head and leg elevation adjustments.
Heavy Duty Hospital Bed (E0303)	☐	Electric height, head, and leg adjustments, supports a patient weighing more than 350 lbs. up to 600 lbs.

PLEASE SUBMIT THIS FORM ALONG WITH A FACE TO FACE, AND CLINICAL NOTES, i.e. doctors, progress, nurses, occupational therapy, and physical therapy notes. The notes must include diagnosis and the need for the equipment. Also, it is required that the date of this form is the same or after the date on the Clinical Notes and Face to Face.

The following criteria must be met for the above selected item to be covered, **(this information has been obtained from the Medicare Policy)**

Qualifies for Fixed Height	1	The beneficiary has a medical condition which requires positioning of the body in ways not feasible with an ordinary bed, OR
Qualifies for Fixed Height	2	The beneficiary requires positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain, OR
Qualifies for Fixed Height	3	The beneficiary requires the head of the be to be elevated more than 30 degrees most of the time due to CHF, COPD, or problems with aspiration, OR
Qualifies for Fixed Height	4	The beneficiary requires traction equipment, which can only be attached to a hospital bed, AND
Qualifies for Variable Height	5	The beneficiary meets one or more of 1 - 4, and requires a bed height different than a fixed height bed to permit transfer to a chair, wc, or standing position, OR
Qualifies for Semi-Electric	6	The beneficiary meets one or more of 1 - 4, and requires frequent or immedicate changes in body position.
Qualifies for Heavy Duty	7	The beneficiary meets one or more of 1 - 4, and weight is more than 350 lbs. but does not exceed 600 lbs.

If the criteria are not met, or proper documentation is not received the hospital bed will be denied as not medically necessary.

Physician Name: ______________________________ **NPI:** ______________________

Physician Signature: ______________________________ **Date :** ______________________

Physician Phone: ______________________________ **Fax:** ______________________

I certify that I am the treating physician identified on this form. Any statement on my letterhead attached here to, has been reviewed and signed by me. I certify that the medical necessity information on this form 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.