



**CERTIFICATION OF MEDICAL NECESSITY FOR HOSPITAL BED**

Bed Prescribed:  Manual Bed  Semi-electric Bed  Full-electric Bed

A separate letter from the ordering physician is required to justify the need for a semi-electric or total electric hospital bed.

Form with fields for: Certification Type/Date, Members Name, Members Medicaid Number, Patient DOB, Sex, HT, WT, Suppliers Name, Suppliers NPI Number, Physicians Name, Physicians NPI Number, HCPCS Code(s), Place of Service.

Primary Diagnosis \_\_\_\_\_ ICD-10 Diagnosis Code \_\_\_\_\_

Secondary Diagnoses supporting medical necessity: \_\_\_\_\_

ICD 10 Diagnosis Code(s) \_\_\_\_\_ Length of Need \_\_\_\_\_

List specific physical limitations which require a hospital bed versus a home bed: \_\_\_\_\_

Percentage of time member is alone % \_\_\_\_\_ Percentage of time confined to bed % \_\_\_\_\_

Member is bound to:  Bed  Wheelchair Is member able to ambulate with assistance?  YES  NO

If yes, type of assistance \_\_\_\_\_

Is member able to ambulate alone?  YES  NO If yes, justify need \_\_\_\_\_

Primary In-Home Caregiver \_\_\_\_\_ (Excludes member or physician)

Physical condition of caregiver \_\_\_\_\_

Is caregiver capable of adjusting a manual bed?  YES  NO

If no, explain \_\_\_\_\_

Describe the positions needed in a hospital bed which are not possible in an ordinary bed: \_\_\_\_\_

Have pillows, wedges, frame elevator, etc. been tried?  YES  NO

Describe success of above: \_\_\_\_\_

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

Additional comments: \_\_\_\_\_

Date of prior surgery or CVAs: \_\_\_\_\_

I certify that the hospital bed requested is medically necessary for this member, and that I have had a face-to-face evaluation with this member within the six (6) months preceding this order, and I am enrolled with Georgia Medicaid for the purpose of ordering, referring, or prescribing medical services.

Date of face-to-face evaluation \_\_\_\_/\_\_\_\_/\_\_\_\_ (Must have occurred within 180 days prior to the order date)

Physician's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Stamps are not an acceptable form of authentication for the date or signature on a certificate of medical necessity or prescription/written order submitted to Georgia Medicaid.

\*\*Semi and Full Electric Beds require separate MD note on Letterhead explaining need\*\*