Ohio Department of Job and Family Services

CERTIFICATE OF MEDICAL NECESSITY/PRESCRIPTION HOSPITAL BEDS

***Instructions:** The Certificate of Medical Necessity (CMN) must be used for all eligible hospital beds under the Ohio Medicaid Program. This form must be completed and carry the proper signature, where indicated, before requests will be considered for prior authorization.*

Name of Consumer	Provider NPI # 1770583288	
Consumer Medicaid #	Provider Medicaid Legacy Number# *(Optional)* 0333740	
Consumer Address	City/State/Zip	Date of Birth

☐ Rental ☐ Purchase	Were pillows or wedges considered prior to requesting bed? ☐ Yes ☐ No	Were rental dates previously approved? ☐ Yes ☐ No If "yes", list Prior Authorization # _____ Authorized dates _____	Consumer's Weight Consumer's Height

Section A - Must be completed by Prescriber

Diagnosis(es) (ICD-9 Code)	**Diagnosis(es) (ICD-9 Description) (Optional)**	☐ Congestive heart failure ☐ Chronic pulmonary disease ☐ Documented problems with aspiration

Check/Complete all that apply

☐ Consumer's diagnosis/physical condition requires positioning of the body in ways not feasible in an ordinary bed due to a medical condition which is expected to last at least one month. (Include severity and frequency of symptoms.) Explain

☐ The consumer requires, for the alleviation of pain, positioning of the body in ways not feasible with an ordinary bed.

☐ The consumer's medical condition requires 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.

☐ Bed is medically necessary during post-surgical period. Date of Surgery

☐ Consumer requires traction equipment which can only be attached to a hospital bed.

☐ The consumer requires a bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair, or standing position

☐ Bed is required to facilitate frequent interventions by a care giver (e.g., turning the consumer every two hours).
Explain - describe interventions/treatments and specify type of care giver.

Transferring	Independent	With assistance	Re-positioning	Independent	With assistance
	☐	☐		☐	☐
Other, specify				☐	☐

Length of time needed
☐ Short-term (less than 10 months)
Specify # of months: _____
☐ Long-term (10 months or more)

Type of bed requested (specify if bed is Heavy Duty or Pediatric)
☐ Variable height, manual
☐ Semi-electric
☐ Other, specify _____

Explain why "variable-height, manual" bed will NOT meet medical needs.

Section B - Prescriber Attestation and Signature/Date

Prescriber Name (*PRINTED*)

Prescriber NPI#

I certify that I am the prescriber identified above. I certify that the information I have completed in this certificate is of medical necessity and any information on any attached documents signed and dated by me is true to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber Signature	Date	Prescriber Medicaid Legacy # *(Optional)*