



State of Rhode Island
Executive Office of Health and Human Services
Medicaid Program

CERTIFICATE OF MEDICAL NECESSITY

HOSPITAL BEDS

SECTION A		Certification Type/Date: _____	INITIAL ___/___/___	REVISED ___/___/___
PATIENT NAME, ADDRESS, TELEPHONE (____) _____ - _____		SUPPLIER NAME, ADDRESS, TELEPHONE (____) _____ - _____		
PLACE OF SERVICE _____ NAME and ADDRESS of FACILITY if applicable	HCPSC CODE: _____	PT DOB ___/___/___; Sex ___(M/F); HT. ___(in.); WT. ___(lbs.)		
		PHYSICIAN NAME, ADDRESS (Printed or Typed) PHYSICIAN'S NPI: _____ PHYSICIAN'S TELEPHONE #: (____) _____ - _____		

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	ANSWER QUESTIONS 1 through 7 for Hospital Beds. (Circle Y for Yes, N for No or D for does not apply)	
Y N D	1. Does the patient 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 <u>more than 30 degrees</u> most of the time due to congestive heart failure, chronic pulmonary disease, or aspiration?	
Y N D	4. Does the patient require traction which can only be attached to a hospital bed?	
Y N D	5. Does the patient require frequent changes in body position and/or have an immediate need for a change in body position?	
Y N D	6. Does the patient require a bed height different than a fixed height hospital bed to permit transfers to chair, wheel chair or standing position?	
Y N D	7. Is the patient able to independently operate controls on a hospital bed?	

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):

NAME: _____ TITLE: _____ EMPLOYER: _____

SECTION C Narrative Description Of Equipment

(1) Narrative description of all items, accessories and options ordered;

SECTION D Physician Attestation and Signature/Date

I certify that I am the 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 ___/___/___ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)