Indiana Health Coverage Programs

MEDICAL CLEARANCE FORM

HOSPITAL AND SPECIALTY BEDS

Section A		
Certification Date: Initial: _____ Revised: ___		
Patient Name: _____ Address: _____		Supplier Name: _____ Address: _____
Phone Number: _____ RID Number:		Phone Number: _____ Provider Number:
Place of Service: _____ Name and address of facility (if applicable)	HCPCS Code:	PT DOB_____; Sex___(M/F) HT_____(IN); WT_____(LBS) Physician Name: Address: Physician UPIN Number: _____ Physician Phone Number: ___

Section B **Information in this section may not be completed by the supplier of the items or supplies*	
Estimated. length of need (number of months_____) Years_____ Lifetime_____	DX codes (ICD) _____ _____ _____ _____

Check Y for Yes, N for No, or NA for Not Applicable for the following questions:	
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 ☐ NA ☐
2. Does the patient require, for the relief of pain, positioning of the body in ways not feasible in an ordinary bed?	Y ☐ N ☐ NA ☐
3. Does the patient require the head of the bed elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease or aspiration?	Y ☐ N ☐ NA ☐
4. Does the patient require traction that can only be attached to a hospital bed?	Y ☐ N ☐ NA ☐
5. Does the patient require a bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair or standing position?	Y ☐ N ☐ NA ☐
6. Does the patient require frequent changes in body position and/or have an immediate need for a change in body position?	Y ☐ N ☐ NA ☐

Section C

**Narrative description of equipment and cost*

(1) Narrative description of all items, accessories, and options ordered; and (2) supplier's charges:

Section D

**Complete this section if you are supplying or ordering a specialty bed. If supplying or providing a hospital bed, skip to Section E.*

What diagnosis qualifies this patient for a specialty bed?		ICD code:
Does this patient have seizures?	Y☐ N☐ NA☐	If yes, what type?
Date of last seizure:	How often do seizures occur?	
Has patient sustained injury related to seizure activity?	Y☐ N☐ NA☐	If yes, what type of injury?

List three safety factors that have been tried and why they failed?

Does this patient have a history of behavior problems that may result in injury, or a history of falls, respiratory problems, cardiac problems or gastrointestinal problems?	Y☐ N☐ NA☐

If yes, document all that apply.

Section E: Physician Signature, Attestation, and Date

I certify that I am the physician listed in section A of this form. I have received sections A through E 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 is Section B is true, accurate and complete to the best of my knowledge, and I understand falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

Physician's Signature: **Date:**