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

CERTIFICATE OF MEDICAL NECESSITY

HOSPITAL BEDS

SECTION A	**Certificate Type/Date:** INITIAL _______ REVISED ________ RECERTIFICATION ________		
PATIENT NAME:		SUPPLIER NAME:	
ADDRESS:		ADDRESS:	
PHONE NUMBER:		PHONE NUMBER:	
PT DOB ___________________ SEX ______ (M/F)		PRESCRIBER NAME:	
HEIGHT __________ (inches) WEIGHT _________ (lbs.)		ADDRESS:	
HCPCS Code: ______________________		PHONE NUMBER:	
		NPI # ____	

SECTION B	Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.
EST. LENGTH OF NEED (# OF MONTHS): _______ (Not to exceed 12)	DIAGNOSIS CODES: ______________ ______________
ANSWERS	ANSWER QUESTIONS 1- 8 for Hospital Beds. (Circle Y for Yes, N for No or D for does not apply)
____________	1. Enter the date of initial face-to-face evaluation.
Y N D	2. 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	3. Does the patient require, for the alleviation of pain, positioning of the body in ways not feasible with an ordinary bed?
Y N D	4. Does the patient require 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?
Y N D	5. Does the patient require traction which can only be attached to a hospital bed?
Y N D	6. Does the patient require frequent changes in body position and/or have an immediate need for a change in body position?
Y N D	7. 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	8. Is the patient able to independently operate controls on the hospital bed ?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PRESCRIBER (Please print):

NAME: _________________________________ | TITLE: __________________________ | EMPLOYER: _______________________

SECTION C **Narrative Description of Equipment**

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

SECTION D **Prescriber Attestation and Signature/Date**

I certify that I am the physician identified above. I certify that the information on this certificate 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: _______________
(SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE.)

Proof of medical necessity is valid for 12 months from the date of issue.