



NORTHEAST MEDICAL PRODUCTS, INC

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HOSPITAL BED ORDER FORM

Patient Name _____ DOB _____

Address _____

Diagnosis codes _____ Ht _____ Wt _____

Length of Need _____ Start Date _____

Equipment ordered:

- _____ E0260 Hospital bed, semi electric, with rails, mattress
- _____ E0303 Hospital bed, heavy duty (350-600lbs), rails, mattress

Coverage Questions:

- Y N Does the patient have a medical condition which requires positioning of the body in ways not feasible with an ordinary bed?
- Y N Does the patient require positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain?
- Y N 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, COPD, or problems with aspiration?
- Y N Have pillows and wedges been considered and ruled out?
- Y N Does the patient require traction equipment, which can only be attached to a hospital bed?
- Y N 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 Does the patient require frequent changes in body position and/or has an immediate need for a change in body position?
- Y N Does the patient weigh 350-600 pounds?

**PLEASE SUPPLY A COPY OF THE NOTES FROM THE FACE-TO-FACE VISIT
(Please be sure to sign, date, and NPI the end of the patient notes)**

Physician Name _____

Address _____

Phone _____ Fax _____ NPI _____

Physician Signature _____

Date _____