Northeast Medical Products, Inc

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An Innova Medical Group Company

INNOVA MEDICAL PRODUCTS

HOSPITAL BED PRESCRIPTION FORM

Patient Name _____ Phone _____

Address _____

Email _____

Diagnosis codes _____ Ht _____ Wt _____

DOB _____ Length of Need _____ Start Date _____

Alternate Contact: Name _____ Relationship _____ Phone _____

Equipment ordered:

_____ E0260 Hospital bed, semi electric, with mattress, rails (check 1): ___ Full Rail ___ Half Rail

_____ 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 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
(ALL CLINICAL NOTES MUST BE EITHER ELECTRONICALLY SIGNED OR HAVE A WET SIGNATURE)

Physician Name _____ NPI _____

Address _____

Phone _____ Fax _____

_____ _____
Physician Signature Date