inter phase
Partners In Healthcare

Hospital Bed Prescription Form

Phone: 215-743-1100 & 800-344-1550 Fax: 215-743-0105

Patient Information ******Please Attach Face Sheet w/ Patient Demographics & Insurance Information******

Patient Name_____ Date of Birth_____

*Preferred Language*_____ Patient Cannot Accept Deliveries on the following days (circle) *Mon Tues Wed Thu Fri Sat*

Height:_____ Weight:_____

Primary Diagnosis	***Secondary Diagnosis***
*ICD-10 Code:*_____	*ICD-10 Code:*_____
***Non-Specified Codes will not qualify for Primary Diagnosis.*	

Equipment (Circle One)

☐ **Manual Hospital Bed** ☐ **Semi-Electric Hospital Bed**

☐ **Full Electric Hospital Bed** ☐ **Other_____**

Order Date_____/_____/_____ Start Date _____/_____/_____ Length of Need_____ Months

Questions to determine medical necessity & justify Hospital Bed	***Circle One***
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?	Yes or No
Does the patient require, for the alleviation of pain, positioning of the body in ways not feasible in an ordinary bed?	Yes or No
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?	Yes or No
Does the patient require traction that can only be attached to a hospital bed?	Yes or No
Does the patient require a bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair or standing position?	Yes or No
Does the patient require frequent changes in body position and/or have an immediate need for a change in body position?	Yes or No
Is the patient able to independently operate the control of a semi-electric or full electric hospital bed?	Yes or No

I certify that the above products are medically necessary and that the information provided is accurate to the best of my knowledge. By signing below, I acknowledge that I have obtained the patient's authorization to release the above information and other medical information that maybe disclosed. I certify that my decision to prescribe this recommended product was based solely based on my determination of medical necessity set forth herein.

Facility Name_____ Contact Person_____ Fax/Email_____

Phone Number_____ Address_____

Ordering Physician (Please Print)_____ NPI #_____ License #_____

Physician Signature_____ **Date** _____/_____/_____ Pecos Certified *(circle one) Yes No*

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