PHONE: 1.888.248.1975 FAX: 1.888.248.2026
EMAIL: connect@chcsolutions.com

CONTINUUM CONNECT HOSPITAL BED ORDER FORM

Please attach face sheet w/ patient demographics & insurance info

PATIENT INFORMATION

Patient Name: ______________________________ DOB: ______/______/__________ Gender: ☐ Male ☐ Female

Language Pref.: ☐ English ☐ Spanish ☐ Other: ___________________

Patient cannot accept deliveries on the following days?
Mon Tues Wed Thurs Fri Sat

Height:___________________ Weight:___________________________

DIAGNOSIS

Primary Diagnosis
ICD-10 Code: ______________________________
*Non-Specified Codes will not qualify for Primary Diagnosis

Secondary Diagnosis
ICD-10 Code: ______________________________

PRODUCTS

Equipment
☐ Manual Hospital Bed
☐ Semi-Electric Hospital Bed
☐ Full Electric Hospital Bed
☐ Heavy Duty Hospital Bed
☐ Other

Order Date: _____/______/______

Patients hip to hip measurement: _____________

Length of Need: ___________ **months**

Questions to determine medical necessity and justify a Hospital Bed

Question	Yes	No
Does this 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	☐ No
Does the patient require, for the alleviation of pain, positioning of the body in ways not feasible in an ordinary bed?	☐ Yes	☐ 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	☐ No
Does the patient require traction that can be only be attached to a hospital bed?	☐ Yes	☐ No
Does the patient require a bed height different than a fixed height hospital bed to permit transfer to chair, wheelchair or standing position?	☐ Yes	☐ No
Does the patient require frequent changes in body position and/or have an immediate need for a change in body?	☐ Yes	☐ No
Is the patient able to independently operate the control of a semi-electric or full electric hospital bed?	☐ Yes	☐ No

REFERRAL INFORMATION

Ref #: ____________________

Practice Name: ______________________________ Fax: ______________________________

Office Address: ______________________________ Email: ______________________________

Phone: ______________________________ Preferred Method of Contact? ☐ Phone ☐ Fax ☐ Email

Contact Person: ______________________________

Physician Name: ____________________ NPI#: ____________________ Phone: (_______)_______-__________ Ext. ________

Physician Signature: ______________________________ Date: ______/______/__________

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 may be disclosed. I certify that my decision to prescribe this recommended product was solely based on my determination of medical necessity set forth herein. This document may serve as a confirmation of a verbal order and is also recorded in the patient's record.

Assignment of Benefits: *I request that payment of my insurance benefits be made to CHC Solutions, Inc., or any of its subsidiaries, for any supplies or services they provide me. I am responsible for any balance due that is not covered by my insurance. I understand any product received in my home cannot be returned if opened. By signing below, I authorize the distribution of my information to CHC Solutions, Inc., or any of its subsidiaries, which may be needed to determine benefits payable for these services or supplies. I authorize CHC Solutions, Inc., or any of its subsidiaries, to forward my medical records to the medical professionals in my care and/or make copies of said records.*

Patient Signature: ______________________________ Date: ______/______/__________

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