CHC
SOLUTIONS, INC.

FAX: 1.844.317.9377
EMAIL: dmeorders@chcsolutions.com

HOSPITAL BED ORDER FORM

Please attach face sheet w/ patient demographics & insurance info
Please attach clinical notes or any relevant documentation

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:_________________________

Emergency Contact Name/Phone Number: ____

DIAGNOSIS

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

PRODUCTS

Equipment

☐ Semi-Electric Hospital Bed	☐ Heavy Duty Hospital Bed *hip-to-hip measurement requirements*
☐ Full-Electric Hospital Bed	☐ Bariatric *hip-to-hip measurement requirements*

Add-Ons

☐ Mattress	☐ Half Side Rails
☐ Egg Crate Mattress Topper	☐ Full Side Rails

Order Date: _____/______/______

Hip-to-Hip Measurement: _____________

Length of Need: ___________ **months (Numeric Form Only)**

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 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 position?	☐ 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, 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.

Call 1.800.220.5262 or visit www.chcsolutions.com for additional information.

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