GEORGIA DEPARTMENT OF COMMUNITY HEALTH

# CERTIFICATION OF MEDICAL NECESSITY FOR HOSPITAL BED

Bed Prescribed: ☐ Manual Bed ☐ Semi-electric Bed ☐ Full-electric Bed

**A separate letter from the ordering physician is required to justify the need for a semi-electric or total electric hospital bed.**

| Certification Type/Date: INITIAL _____/_____/_____ REVISED _____/_____/_____ | |
|---|---|
| **Members Name:** ________________ | **Members Medicaid Number (Do Not List Mother's ID):** ________________ |
| **Patient DOB_____/_____/_____ Sex________ HT.________(in) WT.________(lbs.)** | |
| **Suppliers Name:** ________________<br>**Suppliers NPI Number:** ________________ | Suppliers Address and Telephone Number:<br>________________<br>________________<br>________________ |
| **Physicians Name:** ________________<br>**Physicians NPI Number:** ________________ | Physicians Address and Telephone Number:<br>________________<br>________________<br>________________ |
| **HCPCS Code(s)** | |
| **Place of Service** | |

Primary Diagnosis________________________________ICD-10 Diagnosis Code______________

Secondary Diagnoses supporting medical necessity:________________________________

ICD 10 Diagnosis Code(s)______________________Length of Need ______________________

List specific physical limitations which require a **hospital** bed versus a **home** bed:

________________________________________________________________

Percentage of time member is alone % ______________ Percentage of time confined to bed % ______________

Member is bound to: ☐ Bed ☐ Wheelchair Is member able to ambulate with assistance? ☐ YES ☐ NO

If yes, type of assistance ________________________________________________

Is member able to ambulate alone? ☐ YES ☐ NO If yes, justify need______________________________

Primary In-Home Caregiver ________________________________________**(Excludes member or physician)**

Physical condition of caregiver________________________________________________

Is caregiver capable of adjusting a manual bed? ☐ YES ☐ NO

If no, explain________________________________________________

Describe the positions needed in a hospital bed which are not possible in an ordinary bed:

________________________________________________________________

Have pillows, wedges, frame elevator, etc. been tried? ☐ YES ☐ NO

Describe success of above:________________________________________________

Prognosis: ________________________________________________

Additional comments: ________________________________________________

Date of prior surgery or CVAs: ________________________________________________

I certify that the hospital bed requested is medically necessary for this member, and that I have had a face-to-face evaluation with this member within the six (6) months preceding this order, and I am enrolled with Georgia Medicaid for the purpose of ordering, referring, or prescribing medical services.

Date of face-to-face evaluation ______/______/______ (Must have occurred within 180 days prior to the order date)

Physician's Signature ________________________________________Date______/______/______

**Stamps are not an acceptable form of authentication for the date or signature on a certificate of medical necessity or prescription/written order submitted to Georgia Medicaid.**