

**Hospital Bed:  
DME Medical Review Form**

Quality and Utilization Improvement Dept.	Telephone # (952) 883-5741
DME - Medical Policy	Fax # (952) 853-8714

\*Please answer ALL of the following questions. This information is **REQUIRED** in order to determine if member meets coverage criteria.\*

Member Name:	Date of Birth:	Member #:
Completed by:	Phone #:	Fax #:
MD ordering ( <i>Print Name</i> ) : _____		Date Completed: _____
NPI Number _____		

1. Diagnosis: \_\_\_\_\_
  
2. Describe the medical condition, severity & frequency of symptoms that necessitate the use of a hospital bed. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
  
3. Prognosis (Expected Outcome):  
 Expected to improve     Stable     Declining     Terminal
  
4. Expected length of need: \_\_\_\_\_ # of months     for Life
  
5. Medical condition requires features of a hospital bed (height adjustment, head and foot adjustments) or special attachments, which are not available for use with ordinary beds.  
 Yes  No
  
6. Member's medical condition requires:  
 bed adjustments for transfers  
 frequent or immediate changes in position (at least every 1-2 hours) to:  
      alleviate pain     promote proper body alignment     prevent contractures  
      avoid respiratory infections     avoid aspiration     other \_\_\_\_\_
  
7. Member's current place of residence:  
 Home     SNF/TCU     Assisted Living     Other \_\_\_\_\_
  
8. Additional information  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_