

Ohio Department of Medicaid
CERTIFICATE OF MEDICAL NECESSITY/PRESCRIPTION HOSPITAL BEDS

Instructions: The Certificate of Medical Necessity (CMN) must be used for all eligible hospital beds under the Ohio Medicaid Program. This form must be completed and carry the proper signature, where indicated, before requests will be considered for prior authorization.

Name of Consumer		Provider NPI #	
Consumer Medicaid #		Provider Medicaid Legacy Number# (Optional)	
Consumer Address		City/State/Zip	Date of Birth
<input type="checkbox"/> Rental	Were pillows or wedges considered prior to requesting bed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Were rental dates previously approved? <input type="checkbox"/> Yes <input type="checkbox"/> No	Consumer's Weight
<input type="checkbox"/> Purchase		If "yes", list Prior Authorization # _____ Authorized dates _____	Consumer's Height

Section A - Must be completed by Prescriber

Diagnosis(es) (ICD-9 Code)	Diagnosis(es) (ICD-9 Description) (Optional)	<input type="checkbox"/> Congestive heart failure <input type="checkbox"/> Chronic pulmonary disease <input type="checkbox"/> Documented problems with aspiration
----------------------------	--	---

Check/Complete all that apply

Consumer's diagnosis/physical condition requires positioning of the body in ways not feasible in an ordinary bed due to a medical condition which is expected to last at least one month. (Include severity and frequency of symptoms.) Explain

The consumer requires, for the alleviation of pain, positioning of the body in ways not feasible with an ordinary bed.

The consumer's medical condition requires 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.

Bed is medically necessary during post-surgical period. Date of Surgery _____

Consumer requires traction equipment which can only be attached to a hospital bed.

The consumer requires a bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair, or standing position

Bed is required to facilitate frequent interventions by a care giver (e.g., turning the consumer every two hours).
Explain - describe interventions/treatments and specify type of care giver.

Transferring	Independent	With assistance	Re-positioning	Independent	With assistance
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Other, specify _____				<input type="checkbox"/>	<input type="checkbox"/>

Length of time needed <input type="checkbox"/> Short-term (less than 10 months) Specify # of months _____	<input type="checkbox"/> Long-term (10 months or more)
Type of bed requested (specify if bed is Heavy Duty or Pediatric) <input type="checkbox"/> Variable height, manual <input type="checkbox"/> Semi-electric <input type="checkbox"/> Other, specify _____	Explain why "variable-height, manual" bed will NOT meet medical needs.

Section B - Prescriber Attestation and Signature/Date

Prescriber Name (<i>PRINTED</i>)		
Prescriber NPI#		
<i>I certify that I am the prescriber identified above. I certify that the information I have completed in this certificate is of medical necessity and any information on any attached documents signed and dated by me is true to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.</i>		
Prescriber Signature	Date	Prescriber Medicaid Legacy # (Optional)