Medicaid

Montana Medicaid Certificate of Medical Necessity

Durable Medical Equipment (DME) and Supplies (Rev. October 2014)

Hospital Bed

Section A

Patient Name, Address, Telephone Number, and Date of Birth **Medicaid ID Number**_____	**Physician Name, Address, and Telephone Number** **NPI Number** _____

Residence ☐ Home ☐ Nursing Home ☐ Hospital Rehab Unit ☐ Group Home ☐ Other _____

Diagnosis	**Estimated Length of Need (Months) 1–99 (99=Lifetime)**

Prognosis

Date of Last Evaluation by a Physician	**Physician's Name**

1. Has the patient received a trial in the use of this item? ☐ Yes ☐ No
2. Does the patient have the **physical** and **mental** ability to operate or use the item? ☐ Yes ☐ No
3. Can the patient or caregiver be responsible for the maintenance of this device? ☐ Yes ☐ No
4. Does the patient require positioning of the body in ways not feasible with an ordinary bed? ☐ Yes ☐ No
5. Is elevation of the head at more than 30 degrees required due to ☐ congestive heart failure ☐ chronic pulmonary disease ☐ aspiration?
6. Does the patient require traction which can only be attached to a hospital bed? ☐ Yes ☐ No
7. Does the patient require a bed height different than a fixed height bed? ☐ Yes ☐ No
8. Does the patient require frequent changes in body position and/or have an immediate need for change in body position? ☐ Yes ☐ No
9. Is the patient ☐ Room Confined ☐ Room Confined ☐ Bed Confined
   ☐ Non-Ambulatory ☐ Ambulation Impaired ☐ Other _____
10. Narrative description of **all** items, accessories, sizes and options, etc., **including model numbers**. If additional space is needed, a continued narrative can be attached to this document as long as the pertinent patient and physician information is included at the top of the attachment. Physician's signature must also be included on the attached document).
    ☐ **Yes,** additional attachments **are** included. ☐ **No,** additional attachments **are not** included.

I certify that I am the treating physician identified in this form. I certify that the medical necessity information contained in this document and its attachments are true, accurate, and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in this document may subject me to civil or criminal liability.

Signature and date stamps are not acceptable.

_____ _____

Physician's Signature **Date (mm/dd/yyyy)**