

**CERTIFICATE OF MEDICAL NECESSITY
SUPPORT SURFACES**

SECTION A Certification Type/Date: INITIAL ___ / ___ / ___		REVISED ___ / ___ / ___	RECERTIFICATION ___ / ___ / ___
PATIENT NAME, ADDRESS, TELEPHONE and MEMBER NUMBER (_____) _____ - _____ MEMBER # _____		SUPPLIER NAME, ADDRESS, TELEPHONE and NSC OR applicable NPI NUMBER/LEGACY NUMBER (_____) _____ - _____ NSC OR NPI # _____	
PLACE OF SERVICE _____	HCPCS CODE _____	PT DOB ___ / ___ / ___ Sex ___ (M/F) Ht. ___ (in) Wt. ___ (lbs.)	
NAME and ADDRESS of FACILITY <i>If applicable</i> _____ _____ _____		PHYSICIAN NAME, ADDRESS, TELEPHONE and applicable NPI/LEGACY NUMBER (_____) _____ - _____ NSC OR NPI # _____	
SECTION B Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.			
EST. LENGTH OF NEED (# OF MONTHS); _____ I-99 (99=LIFETIME)		DIAGNOSIS CODES : _____	
ANSWERS		Circle Y for Yes, N for NO or D for Does not apply, unless otherwise noted.	
Y	N	D	1. Is the patient highly susceptible to decubitus ulcers?
Y	N	D	2. Are you supervising the use of the device?
Y	N	D	3. Does the patient have coexisting pulmonary disease?
Y	N	D	4. Has a conservative treatment program been tried without success?
Y	N	D	5. Was a comprehensive assessment performed after failure of conservative treatment?
Y	N	D	6. Are open, moist dressings used for the treatment of the patient?
Y	N	D	7. Is there a trained full-time caregiver to assist the patient and manage all aspects involved with the use of the bed?
8. Provide the stage and size of each pressure ulcer necessitating the use of the overlay, mattress, or bed. If the patient is highly susceptible to decubitus ulcers, but currently has no ulcer present, place "9" under ulcer #1. Pressure Ulcer Ulcer #1 Ulcer #2 Ulcer #3 Site: _____ _____ _____ Stage: _____ _____ _____ Max length (cm): _____ _____ _____ Max width (cm): _____ _____ _____ Depth (cm): _____ _____ _____			
I	2	3	9. Over the past month, the patient's ulcer(s) has/have: 1—Improved 2—Remained the same 3—Worsened?
To expedite timely review, medical records to support the above statement must be submitted at the time of request.			
Name of person answering section B questions, if other than the physician (PLEASE PRINT):			
Name _____ Title _____ Employer _____			
SECTION C Narrative Description of Equipment and Cost.			
(1) Narrative description of all items, accessories, and options ordered; (2) Supplier's charge.			
SECTION D PHYSICIAN Attestation and Signature/Date			
I certify that I am the treating physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed, and signed by me. I certify that the medical necessity information in Section B is true, accurate, and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.			
PHYSICIAN'S SIGNATURE _____		DATE ___ / ___ / ___	