Hospital Bed

Prior Authorization Form

Quality and Utilization Improvement Dept. **Fax: (952) 853-8714** **Phone: 1 (888) 467-0774**

To be completed by a Health Professional (MD, NP, PA, etc), not Vendor or Member. Please fax to Vendor. Vendor: please fax to above number. Please print answers to all of the following questions. This information is required in order to determine whether coverage criteria are met.

Member Name:	Date of Birth: ___/___/_____	Member #:
Form Completed by and date:	Phone #: ( ) ____-_____	Fax #: ( ) ____-_____

MD ordering *(First & Last Name)*: _____NPI#_____

Clinic Phone: ( ) _____-_____ **Clinic Fax :**( ) _____-_____

1. **Diagnosis: _____ICD9 or 10:_____**
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. **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____**
5. **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**
   _____
   _____
   _____
   _____

Physician or Treating Practitioner Signature: **Date:**