**DVHA HOSPITAL BED REQUEST FORM**

**Instructions:** Complete all fields of this form to avoid delays and denials for requested services. Submit the form to the durable medical equipment vendor, who will then fax the form to DVHA at 802 879 5963. Do not use this form for special needs beds.

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| **MEMBER INFORMATION** | | | | | |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Date of Birth: \_\_\_/\_\_\_\_/\_\_\_\_\_ | | Medicaid ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Medical Condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Height: \_\_\_\_\_\_\_\_\_ | | Weight**:** \_\_\_\_\_\_\_\_\_ |
| Transfer assistance needed (minimal, moderate, maximal): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Mobility device (walker, wheelchair) : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Transfer device required (slide board, lift): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |  | | |
| Home is able to accommodate a hospital bed: ☐ Yes ☐ No | | | | | |
| Member requires frequent changes in body position and/or has an immediate need for a change in body position to alleviate pain, promote proper alignment, prevent contracture, or avoid pulmonary complications  Yes  No | | | | | |
| Member has a condition which requires bed adjustments to position the body in ways not feasible with an ordinary bed and elevation greater than 30 degrees is required  Yes  No | | | | | |
| Member requires that the head of the bed be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease, or aspiration risk, where pillows or wedges have been considered and ruled out.  Yes  No | | | | | |
| Member requires traction equipment which can only be attached to a hospital bed  Yes  No | | | | | |
| Member requires a bed height different that a fixed height bed to permit transfers to a chair, wheelchair, or standing position  Yes  No | | | | | |
| Member requires electric height adjustment to perform sliding board or other types of transfers (required for fully electric beds)  Yes  No | | | | | |
| Member requires a hospital bed with a weight capacity greater than 350#  Yes  No | | | | | |
| Member requires a hospital bed with a weight capacity greater than 600#  Yes  No | | | | | |
| **TYPE OF DEVICE NEEDED** | | | | | |
| E0250-E0251 Manual bed | | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| E0255-E0256 Variable height bed | | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| E0260-E0261 Semi electric bed, electric adjustment for head and foot | | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| E0265-E0266 Total electric bed (electric adjustment for head, foot, and bed height) | |  | | | |
| E0301-E0304 Bariatric bed | | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Other (specify) | | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **TYPE OF ACCESSORIES NEEDED (Check All That Apply)** | | | | | |
| Siderails: full partial | | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Trapeze: floor mount  bed mount | | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Mattress: standard | | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Foam overlay | | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Gel overlay | | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Alternating air pressure overlay | | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| ☐ Low air loss mattress | | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| ☐ Other mattress | | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Other accessory (specify) | | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **ADDITIONAL COMMENTS:** | | | | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Provider Contact Info: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| Provider professional designation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | | | | |