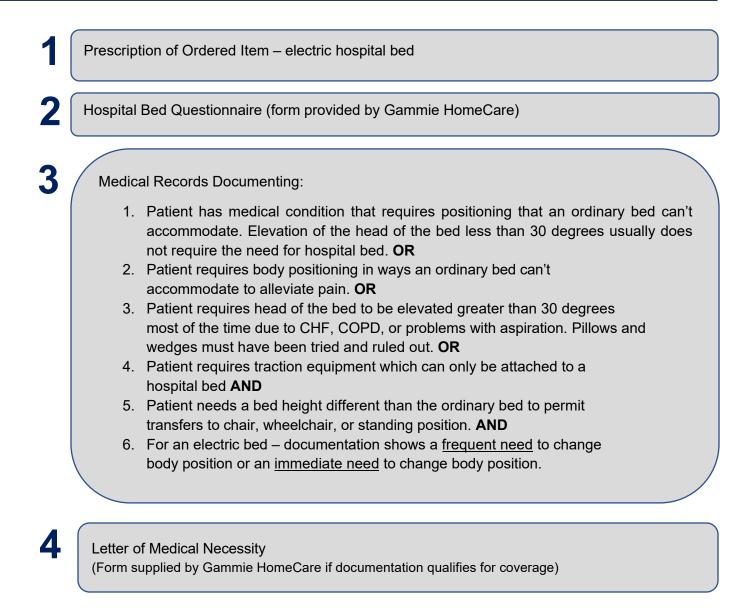


Gammie HomeCare

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Hospital Bed Insurance Coverage Criteria



Coverage criteria is taken from the CMS Medicare Local Coverage Determination policies. These guidelines are subject to change without notice. Last Updated 8.16.19.

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Hospital Bed Questionnaire

Please answer the following questions <u>and</u> provide supporting documentation from the patient's medical record. The questionnaire does not replace the requirement for documentation in the medical record.

| Patient Name: | | Date of Birth: | |
|---------------------------|--|--|---|
| ICD10 | :, | ;; | 3 |
| 1. 2. | What is the duration of need for a | or chronic condition? | |
| 3. | (Note: elevation of the head / upp □ Yes □ No If yes, specify: a. Medical Condition: | condition which requires positioning of the boo per body less than 30 degrees does not usuall | y require the use of a hospital bed)? |
| 4. | in order to alleviate pain? If yes, specify: a. Medical Condition: | condition which requires positioning of the boo | |
| 5. | failure, chronic pulmonary diseas If yes, specify: a. Medical Condition: | d of the bed to be elevated more than 30 degr se, or problems with aspiration? □ Yes □ No | |
| 6. | Does the patient have a medical Yes No If yes, specify: | condition which requires traction equipment th | nat can only be attached to hospital bed? |
| 7. | Does the patient require a bed he standing position? | eight different than a fixed height hospital bed | to permit transfers to chair, wheelchair or |
| 8. | If yes, specify: a. Medical Condition: b. Position Required: | condition which requires frequent changes in | |
| 9. | If yes, specify: a. Medical Condition: | condition which requires immediate need for a | a change in body position? Yes No |
| Printed Name of Evaluator | | Signature of Evaluator | Date |
| Printed Name of Physician | | Signature of Physician | Date |