CERTIFICATE OF MEDICAL NECESSITY

DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 785 (3-2006)

Clear Fields

HOSPITAL BEDS

SECTION A - Certification Type/Date:

Date	☐ Initial ☐ Revised
Name	Patient ID

SECTION B - Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.

EST. LENGTH OF NEED (# OF MONTHS): _____ 1-99 (99=LIFETIME)

1. Does the patient require positoning of the body in ways not feasible with an ordinary bed due to a medical conditon which is expected to last at least one month? ☐ Yes ☐ No ☐ Does Not Apply

2. Does the patient require, for the alleviation of pain, positioning of the body in ways not feasible with an ordinary bed? ☐ Yes ☐ No ☐ Does Not Apply

3. Does the patient require the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease, or aspiration? ☐ Yes ☐ No ☐ Does Not Apply

4. Does the patient require traction which can only be attached to a hospital bed? ☐ Yes ☐ No ☐ Does Not Apply

5. Does the patient require a bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair, or standing position? ☐ Yes ☐ No ☐ Does Not Apply

6. Does the patient require frequent changes in body positon and/or have an immediate need for a change in body postion? ☐ Yes ☐ No ☐ Does Not Apply

SECTION C - Narrative Description

Narrative description of all items, accessories and options ordered.

SECTION C Physician Signature/Date

Signature	Date	(Signature and Date Stamps are not acceptable)