APPENDIX N

CERTIFICATION FOR HOSPITAL BED

Alliant GMCF
PA/UM Department
PO Box 105329
Atlanta, GA 30346

Member Medicaid Number ___ Date of Birth ____________
Member Full Name ____
Diagnoses_______________________________ICD-9 Codes________________
Weight: _______________ Height: ____________(Height & weight are required)

❐ Manual Bed ❐ Semi-electric Bed * ❐ Full-electric Bed*
***Separate M.D. letter required for semi-electric and full-electric bed**

List *specific* physical limitations which require a ***hospital*** bed versus a ***home*** bed:

____

Percentage of time left alone _________%
Percentage of time bed-confined _______%

Check all applicable and complete the blanks:
❐Bedbound ❐Bed to chair bound
❐Ambulates with assistance. Describe assistance.____________________________
❐Capable of ambulating alone. Why is bed needed?___________________________

Primary Caregiver ___________________________ (not member; not MD)
Physical condition of caregiver ____
Is caregiver capable of adjusting a manual bed?_________ If no, why not? ________

____

Describe the positions needed in a hospital bed which are not possible in an ordinary bed:

____

Have pillows, wedges, frame elevator, etc. been tried? ❐YES ❐NO
Describe success of above. ____
Prognosis ____
Additional comments ____
Date of surgeries or CVAs: ____

Physician Signature* ______________________________ **Date** ___________
Physician's printed name____
Address____
***Stamped signatures or dates are not acceptable**