PRISM HEALTH CARE SERVICES, INC.
MEDICAL SUPPLIES + RESPIRATORY EQUIPMENT

Hospital Bed

Standard Written Order (SWO)

Prism Health Care Services, Inc.
1337 Basswood Road
Schaumburg, IL 60173-4353
Phone: 847-310-4730 *3
Fax: 872-469-1673

Order Date: _____

Patient Name: _____ Home Phone: _____

Date of Birth: _____ Cell Phone: _____

Diagnosis: 1 _____ 2 _____ 3 _____

Select a bed based on description and need.

Fixed Height Hospital Bed (E0250)	☐	Manually adjust head and leg elevation. Height adjustment is not needed.
Variable Height Hospital Bed (E0255)	☐	Manually adjust height, head, and leg elevation.
Semi-Electric Hospital Bed (E0260)	☐	Manually adjust height, electric head and leg elevation adjustments.
Heavy Duty Hospital Bed (E0303)	☐	Electric height, head, and leg adjustments, supports a patient weighing more than 350 lbs. up to 600 lbs.

PLEASE SUBMIT THIS FORM ALONG WITH A FACE TO FACE, AND CLINICAL NOTES, i.e. doctors, progress, nurses, occupational therapy, and physical therapy notes. The notes must include diagnosis and the need for the equipment. Also, it is required that the date of this form is the same or after the date on the Clinical Notes and Face to Face.

The following criteria must be met for the above selected item to be covered,
(this information has been obtained from the Medicare Policy)

Coverage Criteria

Qualifications for Fixed Height	1	The beneficiary has a medical condition which requires positioning of the body in ways not feasible with an ordinary bed, OR
Qualifictions for Fixed Height	2	The beneficiary requires positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain, OR
Qualifications for Fixed Height	3	The beneficiary requires the head of the bed to be elevated more than 30 degrees most of the time due to CHF, COPD, or problems with aspiration, OR
Qualifications for Fixed Height	4	The beneficiary requires traction equipment, which can only be attached to a hospital bed, AND
Qualifications for Variable Height	*	The beneficiary meets one or more of 1 - 4, and requires a bed height different than a fixed height bed to permit transfer to a chair, wheelchair, or standing position, OR
Qualifications for Semi-Electric	*	The beneficiary meets one or more of 1 - 4, and requires frequent or immediate changes in body position.
Qualifications for Heavy Duty	*	The beneficiary meets one or more of 1 - 4, and weight is more than 350 lbs. but does not exceed 600 lbs.

If the criteria are not met, or proper documentation is not received the hospital bed will be denied as not medically necessary.

Physician Name: _____ **NPI:** _____

Physician Signature: _____ **Date :** _____

Physician Phone: _____ **Fax:** _____

I certify that I am the treating physician identified on this form. Any statement on my letterhead attached here to, has been reviewed and signed by me. I certify that the medical necessity information on this form is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.