HANDI MEDICAL SUPPLY

Standard Written Order: Hospital Bed

Prescriber Information

Clinic/Location Name:
Prescriber Name:
Prescriber Address:
Prescriber City State Zip:
Prescriber Phone:
Prescriber Fax:
Prescriber NPI:

Patient Information

Patient Name:
Patient Address:
Patient City State Zip:
Phone:
DOB:
Primary Insurance:
Handi Customer Number:

Diagnosis (ICD-10)

Patient Height: _____ **Patient weight:** _____

Hospital Bed* (Required)	Dispensing Qty
☐ HOSPITAL BED, VARIABLE HEIGHT, HI-LO	1 each every 5 years
☐ HOSPITAL BED, SEMI-ELECTRIC	1 each every 5 years
☐ HOSPITAL BED, TOTAL ELECTRIC	1 each every 5 years

Mattress Type* (Required)	Dispensing Qty
☐ MATTRESS, STANDARD (E0271)	1 each every 5 years
☐ MATTRESS, GROUP I (E0184)	1 each every 5 years
☐ MATTRESS, GROUP II (E0277)	1 each every 5 years

Rail Type* (Required)	Dispensing Qty
☐ FULL RAILS	1 each every 5 years
☐ HALF RAILS	1 each every 5 years
☐ NO RAILS	

Accessories* (If Applicable)	Dispensing Qty
☐ TRAPEZE BARS, ATTACHED TO BED	1 each every 5 years
☐ TRAPEZE BAR, HEAVY DUTY, ATTACHED TO BED, WEIGHT CAPACITY > 250 LBS	1 each every 5 years

Subject to coverage criteria. Your patient will be contacted with available options.

1. Ordered Date: _____ **2. Length of Need:** _____

Leaving blank presumes Lifetime (99 months)

3. Please complete the following questions:

A. ☐ **YES** ☐ **NO** **Does the patient have a medical condition which requires positioning of the body in ways not feasible with an ordinary bed?**

B. What is the reason for the bed? ☐ **Elevation > 30 degree** ☐ **Alleviation of pain** ☐ **Traction required**

C. ☐ **YES** ☐ **NO** **Does patient require a bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair or standing position?**

D. ☐ **YES** ☐ **NO** **Does patient require frequent changes in body position and/or has an immediate need for a change in body position?**

4. Please attach medical records supporting necessity of the above ordered item(s).

5. _____ _____
Physician/NP/PA/Medical Practitioner Signature Date

: Signer must match Prescriber Information at the top of this form, or be corrected above

 Form date: 20211119 **Tel: 651-644-9770 or 800-514-9979** 2505 University Avenue West, St. Paul, MN 55114