CERTIFICATE OF MEDICAL NECESSITY

Highmark Blue Shield regulations require the following information be provided on claims for durable medical equipment, prosthetic devices, and orthotic devices. This form should be completed by the patient's physician and returned to us, accompanied by a Health Insurance Claim Form completed by the supplier.

Patient's Name: _____ Agreement Number: _____

Diagnosis: _____

Date this equipment prescribed: _____ Equipment will be needed for: _____ months

Prognosis: _____

This prescription applies to rental period from ____/____/____ to ____/____/____.

Please check the equipment you are prescribing and answer YES or NO to the corresponding question. Equipment with special attachments or features, or equipment not included below should be listed in the space provided.

	YES	NO	
☐ Hospital Bed (Answer A, B)	☐	☐	A. Is the patient bed confined?
☐ Electric Hospital Bed (Answer A, C, D)	☐	☐	B. Does the patient's condition require positioning of the body or attachments which would not be feasible with the use of an ordinary bed?
☐ Side Rails (Answer A, E)	☐	☐	C. Does the patient's condition require frequent and/or immediate changes in body position?
☐ Commode (Answer A, F, N)	☐	☐	D. Can the patient operate the controls himself?
☐ Trapeze Bar (Answer A, G, H)	☐	☐	E. Is the patient disoriented at any time?
☐ Alternating Pressure Pad (Answer I, J)	☐	☐	F. Is the patient room confined?
☐ Wheelchair (Answer K)	☐	☐	G. Is there a need for the patient to sit up due to respiratory conditions, etc.?
☐ Walker (Answer L, M)	☐	☐	H. Is there a medical need for a change in body position?
	☐	☐	I. Is the patient highly susceptible to decubitus ulcers?
	☐	☐	J. Are you supervising the use of pressure pad?
	☐	☐	K. Is the patient's condition such that the alternative would be bed or chair confinement?
	☐	☐	L. Does the patient's condition impair ambulation?
	☐	☐	M. Is the walker used for therapy?
	☐	☐	N. Is the patient confined to floor without bathroom facilities?

If ambulatory equipment such as a walker, cane or quad cane is being used with non-ambulatory equipment such as side rails, trapeze bar, etc., please explain why both are medically necessary.

_____

_____

Items not included above and diagnosis or condition which warrants equipment.

_____

_____

If equipment is not used in the patient's home, please indicate the name and address of the facility where the patient resides (print or type).

_____

_____

Signature of the physician certifies that the above represents his judgment of the patient's need for the equipment.

IMPORTANT: This form must be signed and dated by the prescribing physician before the equipment may be considered for payment. (print or type).

Physician's Name: _____

Physician's Phone No.: _____

Physician's Address: _____

Physician's Signature: _____

Date: _____