APRIA®

Hospital Bed Order Form

Fax completed form to: _____

Apria Representative _____ **Branch Location** _____ **Phone** _____

REFERRAL SOURCE

Referral name _____ Referral contact name _____

Order date _____ Phone _____ Fax _____

PATIENT INFORMATION

Patient name _____ DOB _____
Last First

Home phone _____ Mobile phone _____ Email _____

Delivery address: Street _____ City _____ State _____ Zip _____

Estimated length of need: _____ months (99 = lifetime) Height _____ Weight _____

Diagnosis ICD-10: Each diagnosis requires a corresponding ICD-10 code and must be corroborated in the patient's medical record. Please enter the appropriate qualifying diagnoses and corresponding ICD-10 codes (Note: ranges are not acceptable). _____

PLEASE PROVIDE SUPPORTING DOCUMENTATION FROM THE MEDICAL RECORD AND PATIENT DEMOGRAPHICS AND INSURANCE INFORMATION

All qualifying criteria MUST BE DOCUMENTED in the patient's medical record.

Fixed height hospital beds are covered if one or more criteria is met:

- Patient's condition requires positioning of the body in ways not feasible in an ordinary bed, ***or***
- Patient requires positioning of the body in ways not feasible in an ordinary bed in order to alleviate pain, ***or***
- Patient requires 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 problems with aspiration, ***or***
- Patient's condition requires traction equipment which can only be attached to a hospital bed.

For a variable height bed:

- The patient meets at least one requirement for a fixed height hospital bed, ***and*** the patient requires a bed height different than a fixed height bed to permit transfers to a chair, wheelchair or a standing position.

For a semi-electric bed:

- The patient meets at least one requirement for a fixed height hospital bed, ***and*** the patient's condition requires frequent changes in body position and/or the patient has an immediate need for a change in body position.

For a heavy-duty extra wide bed:

- The patient meets at least one requirement for a fixed height hospital bed, ***and*** weighs more than 350 lbs, but does not exceed 600 lbs.

For an extra heavy-duty bed:

- The patient meets at least one requirement for a fixed height hospital bed, ***and*** weighs more than 600 lbs.

For trapeze equipment, the following criteria also must be met:

- The patient needs this device to sit up because of a respiratory condition, to change body position for other medical reasons, or to get in or out of bed.

For heavy-duty trapeze equipment, the following criteria also must be met:

- The patient meets requirements for trapeze equipment, ***and*** weighs more than 250 lbs.

EQUIPMENT ORDERED

- ☐ Hospital bed, semi-electric, w/ any type side rails and mattress (E0260)
- ☐ Hospital bed, semi-electric, w/out side rails or mattress (E0295)
- ☐ Hospital bed, total electric, for pts < 450 lbs., w/out side rails or mattress (E0297)
- ☐ Trapeze bars (patient helper), attached to bed, w/ grab bar (E0910)
- ☐ Trapeze bar, free-standing, complete w/ grab bar (E0940)
- ☐ Trapeze bar, heavy duty, for pts > 250 lbs., attached to bed, w/ grab bar (E0911)
- ☐ Trapeze bar, heavy-duty, for pts > 250 lbs., free-standing, complete w/ grab bar (E0912)
- ☐ Other _____

By my signature below, I authorize the use of this document as a dispensing prescription. I understand that the final decision with respect to ordering this (these) item(s) for this patient is a clinical decision made by me, based on the patient's clinical needs, and that my records concerning this patient support the medical need for the items prescribed.

Print prescriber's name _____ **Prescriber email** _____ **NPI #** _____

Prescriber's signature _____ **Date** _____

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