Hastings Home Health Center Cleveland
15210 Industrial Parkway
Cleveland, OH 44135-3308
216-898-3300

Statement of Medical Necessity

Patient Name:		**Start of Care:**	
Address:		**MRN:**	
City/St/Zip:		**DOB:**	
Phone		**Gender:**	

Diagnosis #1:		**Date Last Seen:**	
Diagnosis #2:		**Prognosis:**	
Diagnosis #3:		**Length of Need:**	
Diagnosis #4:		**Access:**	

This is to certify that the below listed items were ordered on: / /

Product Description	Quantity	Frequency

Statement of Medical Necessity:

<> THE STATEMENT BELOW CANNOT BE COMPLETED BY THE SUPPLIER OR ANYONE IN A FINANCIAL RELATIONSHIP WITH THE SUPPLIER <>

PATIENT HAS IMPAIRED MOBILITY AND REQUIRES A PRESSURE REDUCING SUPPORT SURFACE.

{ } E0181 Alternating pressure pad and pump   { } E0185 Gel pressure pad for mattress

INDICATE WHICH OF THE FOLLOWING CONDITIONS DESCRIBE THE PATIENT
(check all that apply):

[ ] COMPLETELY IMMOBILE AND CANNOT MAKE CHANGES IN BODY POSITION WITHOUT ASSISTANCE
[ ] LIMITED MOBILITY AND CANNOT INDEPENDENTLY MAKE CHANGES IN BODY POSITION TO ALLEVIATE PRESSURE
[ ] PRESSURE ULCERS ON THE TRUCK OR PELVIS
[ ] IMPAIRED NUTRITIONAL STATUS
[ ] FECAL OR URINARY INCONTINENCE
[ ] ALTERED SENSORY PERCEPTION
[ ] COMPROMISED CIRCULATORY STATUS

PLEASE CONFIRM THAT THE PATIENT'S MEDICAL RECORD CONTAINS SUPPORTING DOCUMENTATION FOR THE AFFIRMATIVE RESPONSES ABOVE. IF NONE OF THE ABOVE APPLY, ATTACH A SEPERATE SHEET DOCUMENTING MEDICAL NECESSITY FOR THE ITEM ORDERED.

ESTIMATED LENGTH OF NEED: __________ (99 = LIFETIME)

Physician's Certificate:

I certify / recertify that the above listed products / services are Medically Necessary and that this patient is under my care.

Physician's Signature: ______________________________   **UPIN:**

Date: ____________

Date Printed: 09/07/2016