028363

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
E0277	Mattress Low Air Loss Alt Pressure	1	

Statement of Medical Necessity:

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

CHECK 'Y' FOR YES, 'N' FOR NO, AND 'D' FOR DOES NOT APPLY, UNLESS OTHERWISE NOTED

[ ]Y [ ]N [ ]D a) DOES THE PATIENT HAVE MULTIPLE STAGE II ULCERS ON THE TRUNK OR PELVIS?

[ ]Y [ ]N [ ]D b) HAS THE PATIENT BEEN ON A COMPREHENSIVE ULCER TREATMENT PROGRAM FOR AT LEAST THE PAST MONTH WHICH HAS INCLUDED THE USE OF AN ALTERNATING PRESSURE OR LOW AIR LOSS OVERLAY WHICH IS LESS THAN 3.5 INCHES , OR A NONPOWERED PRESSURE REDUCING OVERLAY OR MATTRESS?

[ ]1 [ ]2 [ ]3 c) OVER THE PAST MONTH, THE PATIENT'S ULCER(S) HAVE:
1) IMPROVED, 2) WORSENED, OR 3) REMAINED THE SAME?

[ ]Y [ ]N [ ]D d) DOES THE PATIENT HAVE LARGE OR MULTIPLE STAGE III OR IV PRESSURE ULCER(S) ON THE TRUNK OR PELVIS?

[ ]Y [ ]N [ ]D e) HAS THE PATIENT HAD A RECENT (WITHIN THE LAST 60 DAYS) MYOCUTANEOUS FLAP OR SKIN GRAFT FOR A PRESSURE ULCER ON THE TRUNK OR PELVIS? IF YES, PROVIDE DATE OF SURGERY: _____

[ ]Y [ ]N [ ]D f) WAS THE PATIENT ON AN ALTERNATING PRESSURE, A LOW AIR LOSS MATTRESS/BED, OR AN AIR FLUIDIZED BED IMMEDIATELY PRIOR TO A RECENT (WITHIN THE LAST 30 DAYS) DISCHARGE FROM A HOSPITAL OR NURSING FACILITY?

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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: _____