

Hospital Bed Order

North Shore Home Medical Supply

To Whom it may concern:

104 Newbury St.
Peabody, MA 01960

Please review the following documents and fill out accordingly. In order for us to bill your patient's insurance, these documents are required. Please include all pertinent patient information such as:

Phone number: 978-535-3893
Fax number: 617-497-4021

- Patient name
- Date of Birth
- Address
- Insurance information (including secondary insurance if applicable)
- Contact information
- Emergency contact information if necessary
- Diagnosis
- Patient height/weight

If you have any questions, do not hesitate to call us at 978-535-3893. Please fax completed documents to **617-497-4021**.

Thank you.

North Shore Home Medical Supply Staff

All orders for insurance will be processed through our subsidiary Ciampa Apothecary.

Hospital Bed Order

Prescriber Information

Please fax completed form to us @ 617-497-4021

Prescriber Name:	
Address:	
Phone Number:	
Fax Number:	
NPI	

Patient Information

*You may also attach face sheet if it contains the following information

Patient Name:	Date of Birth:
Address:	Height:
	Weight:
Phone Number:	Emergency Contact:
Primary Insurance/ID#	Secondary Insurance/ID#
Diagnosis:	Length of Need:

Additional Information:	
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For Coverage of a hospital bed, one of the following criteria must be met; please check all that are applicable:

The patient has a medical condition which requires positioning of the body in ways not feasible with an ordinary bed.

The patient requires positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain.

The 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. Pillows or wedges must have been considered and ruled out.

The patient requires traction equipment which can only be attached to a hospital bed.

A variable height, semi-automatic hospital bed is covered when either of the following criteria are met:

1. The patient requires a bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair or standing position.
2. The patient requires frequent or immediate changes in body position.

Does the patient meet either of these conditions? Yes No (Please circle which is applicable)

Prescriber Signature:	Date:
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