Detailed Written Order

Medicare regulations mandate that all of the following elements be included on the prescription/written order for a Hospital Bed. **Also, please fax the chart notes from the face-to-face exam that relate to the equipment being ordered.**

Beneficiary Name: _____

Medicare Number: _____ Date of Birth: _____

Description of the item ordered:

Semi-Electric Hospital Bed with Mattress

Heavy Duty Hospital Bed with Mattress

Accessories needed for hospital bed that has been ordered:

Please choose the type of rails to be included with the bed

Full **Half** **None**

Please indicate if you would like a Trapeze bar include with the bed

Trapeze Bar: **Yes** **No**

Face-to-face examination completion date: _____

Pertinent diagnoses/conditions that relate to the need for the item or items ordered:

_____

_____

Length of need in months: (99 = lifetime) _____

Physician's Name: _____ NPI # _____

Physician's signature: _____ Date: _____

******PLEASE FAX THIS ORDER TO 704-256-1500******

Any problems faxing you may call 704-821-7777