



Hospital Bed Prescription

Mayo Clinic Store

Form content not retained in medical record.

Route to Mayo Clinic Store for electronic storage.

(complete fields or place patient label here)

Patient Name (First Middle Last)
Birth Date (mm-dd-yyyy)
Mayo Clinic or Store Account Number

Instructions: This form is intended to be used as a prescription in compliance with Medicare billing requirements. Completed prescriptions should be faxed to Mayo Clinic Store or sent with the patient. Submissions should include insurance coverage information and clinical documentation (face-to-face exam, medical justifications) to substantiate medical necessity for insurance billing purposes.

Medicare Requirements

For all hospital beds, there must be documentation in the patients medical record to support the following criteria:

1. Patient's medical condition requires positioning of the body in ways not feasible with an ordinary bed; or
2. Patient requires positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain; or
3. 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
4. Patient requires traction equipment, which can only be attached to a hospital bed.

For Semi-Electric Hospital Beds: There must be documentation the patient requires frequent changes in body position and/or has an immediate need for a change in body position.


Order Information

Order Date (mm-dd-yyyy)	Start Date (mm-dd-yyyy)	Need Length <input type="checkbox"/> Lifetime <input type="checkbox"/> Other _____	
Qualifying Diagnosis (ICD-10)		Patient Height (inches)	Patient Weight (pounds)
Date of Face-to-Face Examination (mm-dd-yyyy)		Patient Phone	

Device and Accessories

Type of Hospital Bed (check one) <input type="checkbox"/> Fixed height hospital bed* <input type="checkbox"/> Variable height hospital bed* <input type="checkbox"/> Semi-electric hospital bed* <input type="checkbox"/> Total electric hospital bed* (Medicare non-covered) <input type="checkbox"/> Heavy-duty, extra-wide hospital bed** * Standard bed weight limit ≤ 350 pounds ** Bariatric bed weight limit > 350 to 600 pounds	Accessory <input type="checkbox"/> Trapeze equipment (E0910) – weight limit 250 pounds <input type="checkbox"/> Heavy-duty trapeze equipment (E0912) – weight limit 1,000 pounds <input type="checkbox"/> Alternating pressure pump (E0181) and air pressure pad (E0197) <input type="checkbox"/> Over bed table (E0274)
Rail Type (check one) <input type="checkbox"/> Half rails <input type="checkbox"/> Full rails	Mattress (check one) <input type="checkbox"/> With mattress <input type="checkbox"/> Without mattress
Special Instructions	

Referring Provider Information and Signature

Facility	Phone	Fax
Provider Signature 		Date (mm-dd-yyyy)
Provider Printed Name (First Middle Last)		National Provider Identifier