Atlantic HEALTHCARE PRODUCTS
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Hospital Bed Equipment Order

PATIENT INFORMATION

Patient:________________________________
DOB:__________________________________
Order Date:______________________________

Patient Contact Number: ______________________
Patient Height: ______________________________
Patient Weight:______________________________

DIAGNOSIS

❑ DX Code:_______________________________________
❑ Length of need: 99 or _______

Hospital Bed Type
- ☐ Fixed Height Hospital Bed
- ☐ Semi-Eletric Hospital Bed
- ☐ Full-Electric Hospital Bed
- ☐ Heavy Duty Hospital Bed (over 350 lbs)

Pressure Relief Surfaces
- ☐ Pressure Reducing Gel Overlay
- ☐ APP

(Require a Group 1 Pressure Relief Form)

Related Items:
- ☐ Trapeze
- ☐ Patient / Hoyer Lift
- ☐ Commode

PHYSICIAN INFORMATION

Practitioner's Name:____
NPI:____

Practitioner's Signature **Date**

Qualifying chart notes need to include

Qualifies for Fixed Height Bed	1.The beneficiary has a medical condition which requires positioning of the body in ways not feasible with an ordinary bed, ***(Or)*** 2.The beneficiary requires positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain, **(Or)** 3.The beneficiary requires the head of the bed to be elevated more than 30 degrees most of the time due to CHF, COPD, or problems with aspiration, **(Or)** 4.The beneficiary requires traction equipment , which can only be attached to a hospital bed, ***AND***
Qualifies for Semi Electric Bed	5.The beneficiary meets one or more of 1-4 and requires a bed height different than a fixed height bed to permit transfer to a chair, wc, or standing position, (**Or**)
Qualifies for Full Electric Bed	6.The beneficiary meets one or more of 1-4, and requires frequent or immediate changes in body position
Qualifies for Heavy Duty Bed	7.The beneficiary meets one or more of 1-4, and weight is more than 350 lbs, but does not exceed 600 lbs.

***Notes**: Fax to 561-290-1434 and we will take care of the rest. 1) This Form 2) patient demographic sheet 3) Chart Notes from last office visit*

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