U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0679

CERTIFICATE OF MEDICAL NECESSITY

DMERC 01.02B

SUPPORT SURFACES

SECTION A

Certification Type/Date: **INITIAL** ___/___/___ **REVISED** ___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER
(__ __ __) __ __ __ - __ __ __ __ HICN _____	Allstate Dme 4009 S. Closner Edinburg,TX 785397279 (956-287-8584 __ __ __ __ NSC # 1982847992

PLACE OF SERVICE _____ NAME and ADDRESS of FACILITY if applicable (See Reverse)	HCPCS CODE	**PT DOB** ___/___/___; **Sex** ___ **(M/F)** ; **HT.**_____**(in.)** ; **WT.**_____**(lbs.)** **PHYSICIAN NAME, ADDRESS (Printed or Typed)** **PHYSICIAN'S UPIN:** _____ **PHYSICIAN'S TELEPHONE #: (**__ __ __**)** __ __ __**-** __ __ __ __

SECTION B

Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.

EST. LENGTH OF NEED (# OF MONTHS): _____ **1-99 (99=LIFETIME)** **DIAGNOSIS CODES (ICD-9):** _____ _____ _____ _____

ANSWERS	
	ANSWER QUESTIONS 12,13 & 21 FOR ALTERNATING PRESSURE PADS OR MATTRESSES; 13-22 FOR AIR FLUIDIZED BEDS (Circle **Y** for Yes, **N** for No, or **D** for Does Not Apply, Unless Otherwise Noted)
	QUESTIONS 1-11, 17 AND 18 ARE RESERVED FOR OTHER OR FUTURE USE.
Y N D	12. Is the patient highly susceptible to decubitus ulcers?
Y N D	13. Are you supervising the use of the device?
Y N D	14. Does the patient have coexisting pulmonary disease?
Y N D	15. Has a conservative treatment program been tried without success?
Y N D	16. Was a comprehensive assessment performed after failure of conservative treatment?
Y N D	19. Are open, moist dressings used for the treatment of the patient?
Y N D	20. Is there a trained full-time caregiver to assist the patient and manage all aspects involved with the use of the bed?
	21. Provide the stage and size of each pressure ulcer necessitating the use of the overlay, mattress or bed. If the patient is highly susceptible to decubitus ulcers, but currently has no ulcer present, place a "9" under ulcer #1.
	Pressure Ulcer / Ulcer # 1 / Ulcer # 2 / Ulcer # 3
	Stage: _____ _____ _____
	Max. Length (cm): _____ _____ _____
	Max. Width (cm): _____ _____ _____
1 2 3	22. Over the past month, the patient's ulcer(s) has/have: 1) Improved 2) Remained the same 3) Worsened?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):
NAME: _____ TITLE: _____ EMPLOYER: _____

SECTION C

Narrative Description Of Equipment And Cost

(1) Narrative description of all items, accessories and options ordered; **(2)** Supplier's charge; and **(3)** Medicare Fee Schedule Allowance for each item, accessory, and option. *(See Instructions On Back)*

SECTION D

Physician Attestation and Signature/Date

I certify that I am the physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE _____ DATE _____/_____/_____ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

CMS 842 (4/96)