DOME HOME CARE
24 15TH STREET SUITE 205
BROOKLYN, NY 11215
PHONE (718) 854-5501 FAX (718) 369-5858

DURABLE MEDICAL EQUIPMENT STATEMENT OF ORDERING PHYSICIAN

Beneficiary Name: DOB: Effective Date:
Address: HICN:
City, State, Zip: HT: WT:

DIAGNOSIS/ICD-10: _____ _____ _____ _____ _____

PROGNOSIS (check one): ☐ GOOD ☐ FAIR ☐ POOR ☐ GUARDED

HCPCS CODE	ITEM DESCRIPTION	QTY
E0260	HOSPITAL BED SEMI-ELEC WITH SIDE RAILS AND MATTRESS	1

THE ABOVE IS MEDICALLY NECESSARY BECAUSE:

PLEASE CIRCLE ALL THAT APPLY:

1) The patient has a medical condition which requires positioning of the body in ways not feasible with an ordinary bed. Elevation of the head/upper body less than 30 degrees does not usually require the use of a hospital bed.

2) The patient requires frequent changes in body position and/or has an immediate need for a change in Position. Patient requires positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain.

3) 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.

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

PHYSICIAN NAME: LIC #:
ADDRESS: NPI#:
CITY, STATE, ZIP:

_____ _____
Physician Signature Date

***NOTE TO PHYSICIAN:** BY SIGNING THIS FORM YOU ARE CERTIFYING THAT YOU HAVE SUPPORTING DOCUMENTATION VERIFYING THIS INFORMATION IN THE PATIENTS PERMANENT MEDICAL RECORDS & THE DOCUMENTATION WILL BE AVAILABLE UPON REQUEST.