Certificate of Medical Necessity

Form for support surfaces (mattresses and pads)

BlueCross BlueShield of Kansas

Section 1A – Patient Information

CLEAR DATA

First Name | MI | Address

Last Name | Suffix | City

Phone Number | ID Number | State | ZIP Code | +4 | County

Date of Birth | Height | Weight

Section 1B – Supplier Information

Supplier Name | Address

Phone Number | NPI Number | City

State | ZIP Code | +4 | County

Section 1C – Physician Information

First Name | MI | Address

Last Name | Suffix | City

Phone Number | ID Number | State | ZIP Code | +4 | County

Section 2 – Medical Necessity Information

Note: Physician, if this section is blank, please complete.

Initial Certification Date | Revised Certification Date

Estimated length of need (number of months) _____
1 – 99 (99 = Lifetime)

Diagnosis codes (ICD-10) – separate with a comma:

Yes	No	
☐	☐	Is the patient highly susceptible to decubitus ulcers?
☐	☐	Are you supervising the use of the device?
☐	☐	Does the patient have co-existing pulmonary disease?
☐	☐	Has a conservative treatment program been tried without success?
☐	☐	Was a comprehensive assessment performed after failure of conservative treatment?
☐	☐	Are open, moist dressings used for the treatment of the patient?
☐	☐	Is there a trained full-time caregiver to assist the patient and manage all aspects involved with the use of the bed?
☐	☐	Does the patient currently have decubitus ulcers? (If Yes, provide the state and size of each pressure ulcer necessitating the use of the overlay, mattress or bed on the next page.)

Please continue on the next page.

Section 2 – Medical Necessity Information (continued)

	Ulcer #1	Ulcer #2	Ulcer #3	Ulcer #4
Stage	_____	_____	_____	_____
Length (cm)	_____	_____	_____	_____
Width (cm)	_____	_____	_____	_____

Over the past month, the patient's ulcer(s) has/have: ☐ Improved ☐ Remained the same ☐ Worsened

Section 3 – Physician Attestation and Signature

I certify that I am the physician identified in section 1C of this form. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge.

Your signature required

_____ ____ ____ _____

Physician's Signature (Signature and date stamps are not acceptable) Date Signed