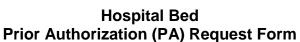


## **Hospital Bed** Prior Authorization (PA) Request Form (Incomplete Form May Delay Processing)

Provider Informa	ation	Member Information
Ordering Physician Name:	NPI #:	Member Name:
Office Phone#: Office Fax#:	Contact Name:	Member ID #:
Vendor Name:	NPI #:	Member's Date of Birth:
Vendor Phone #: Vendor Fax #:	Contact Name:	Member's Phone #:
ICD-10 Code(s):		
	Please answer quest	ions below
HCPCS code(s) (REQUIRED):		
*For accessories and add-on feature HCPCS code(s) for accessories		provide supporting documentation
Date of initial delivery://		
Member Resides in Nursing Facility:		
Member Resides in Nursing Facility.		
E0292, E0293), semi-electric h	ospital bed E0260, E0261, or extra heavy-duty hospital	, E0328), variable height hospital bed (E0255, E0256, E0294, E0295, E0329), heavy duty extra wide bed (E0302, E0304) is covered; if one or more of the
		e in an ordinary bed? Yes No
b. Does the patient require bo	ody positioning for relief of p	pain not possible in an ordinary bed? Yes No
c. Does the patient require he	ead of bed to be elevated?	☐ Yes ☐ No
		ched to a hospital bed? Yes No
Additional coverage to be met:		
2. A variable height hospital be-	d (E0255, E0256, E0292, E	(0293) is covered if the following is met:
·	-	an a fixed height hospital bed to assist with transfers  — Yes — No
3. A semi-electric hospital bed (	(E0260, E0261, E0294, E0	295, E0329) is covered if the following is met:
	-	dy position? Yes No





(Incomplete Form May Delay Processing)

<ul> <li>4. A heavy duty extra wide hospital bed (E0301, E0303) is covered if the following is met:</li> <li>a. Is the member's weight is more than 350 pounds, but does not exceed 600 pounds?   ☐ Yes ☐ No</li> </ul>		
5. An extra heavy-duty hospital bed (E0302, E0304) is covered if the following is met:  a. Does the member's weight exceed 600 pounds?		
I certify that I have appropriate authority to request an organization determination for the item(s) indicated on this request. I further certify that the patient's medical records accurately reflect the information provided. I understand that Experience Health Medicare Advantage <sup>SM</sup> (HMO) may request medical records for this patient at any time in order to verify this information.		
Signature: Date:		

## Please Return Completed Form to:

Fax 1-919-765-7805

For questions please call Care Management at 1-833-941-0107.

Experience Health Medicare Advantage <sup>SM</sup> is a HMO plan. This plan has a Medicare contract. Enrollment in the plan depends on contract renewal.