# Hospital Bed

**Prior Authorization (PA) Request Form**

*(Incomplete Form May Delay Processing)*

<table>
<thead>
<tr>
<th>Provider Information</th>
<th>Member Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ordering Physician Name:</td>
<td>NPI #:</td>
</tr>
<tr>
<td>Office Phone#:</td>
<td>Contact Name:</td>
</tr>
<tr>
<td>Office Fax#:</td>
<td></td>
</tr>
<tr>
<td>Vendor Name:</td>
<td>NPI #:</td>
</tr>
<tr>
<td>Vendor Phone #:</td>
<td>Contact Name:</td>
</tr>
<tr>
<td>Vendor Fax #:</td>
<td></td>
</tr>
</tbody>
</table>

**ICD-10 Code(s):**

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**Please answer questions below**

**HCPCS code(s) (REQUIRED):**

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*For accessories and add-on features, please list codes and provide supporting documentation*

**HCPCS code(s) for accessories**

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**Date of initial delivery:** _ _/_ _/_ _

**Member Resides in Nursing Facility:** □ Yes □ No

1. A fixed height hospital bed (E0250, E0251, E0290, E0291, E0328), variable height hospital bed (E0255, E0256, E0292, E0293), semi-electric hospital bed E0260, E0261, E0294, E0295, E0329), heavy duty extra wide hospital bed (E0301, E0303), or extra heavy-duty hospital bed (E0302, E0304) is covered; if one or more of the following criteria (1-4) are met:

   a. **Does the patient require positioning that is not possible in an ordinary bed?** ……………… □ Yes □ No
   b. **Does the patient require body positioning for relief of pain not possible in an ordinary bed?**.. □ Yes □ No
   c. **Does the patient require head of bed to be elevated?** ……………………………………… □ Yes □ No
   d. **Does the patient require traction that can only be attached to a hospital bed?** …………… □ Yes □ No

**Additional coverage to be met:**

2. A **variable height hospital bed (E0255, E0256, E0292, E0293)** is covered if the following is met:
   a. **Does the member require a bed height different than a fixed height hospital bed to assist with transfers to chair, wheelchair or standing position?** ………………………………………………………………………………………… □ Yes □ No

3. A **semi-electric hospital bed (E0260, E0261, E0294, E0295, E0329)** is covered if the following is met:
   a. **Does the member require frequent changes in body position?** ……………………………. □ Yes □ No

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4. A heavy duty extra wide hospital bed (E0301, E0303) is covered if the following is met:
   a. Is the member’s weight is more than 350 pounds, but does not exceed 600 pounds? Yes □ No □

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? □ Yes □ No

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 SM (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 SM is a HMO plan. This plan has a Medicare contract. Enrollment in the plan depends on contract renewal.