Hospital bed evaluation

Washington State Health Care Authority

Please provide the information below, please print your answer, attach supporting documentation, sign, date, and submit the request as follows:

Online submission: Complete an online submission via the ProviderOne Portal. Submit the HCA prescription form 13-794, this completed form online along with supporting documentation (as needed).

Written submission: Fax a completed General Information for Authorization form (13-835), as the first page of the fax, the HCA prescription form (13-794), this completed form and supporting documentation to the Authorization Services Office at 1-866-668-1214.

1 General information

Client name _____ Date of request _____ Client ProviderOne ID _____

What are the diagnoses that justify medical necessity of a hospital bed? (Please include ICD-10 code and description.)

Length of need (in months) _____ Hours per day client is in bed _____

Supplier name _____ Supplier phone number _____ Supplier fax _____

Billing provider NPI _____

2 Patient information

1. **Hospital bed requested?**
   - ☐ Fixed height
   - ☐ Adjustable height
   - ☐ Semi-electric
   - ☐ Heavy duty
   - ☐ Extra heavy duty

2. **Does the client require the height of the bed to be greater than 30?**
   - ☐ Yes, specify the medical condition related to this need: _____
   - ☐ No

3. **Have pillows, bolsters, foam wedges, or other objects been tried?**
   - ☐ Yes, what was the outcome: _____
   - ☐ No

4. **Why would a fixed height or adjustable height bed not meet the client's needs (caregiver convenience is not considered medically necessary)?**

5. **Does the client require immediate or emergent position change related to their medical condition(s)?**

☐ Yes, please explain:

☐ No

6. **Is the client at risk for aspiration?**

☐ Yes, please explain:

☐ No

7. **For heavy duty and extra heavy duty hospital beds, indicate client's weight and date measured below:**

Client's weight

Date of measurement

3 Additional comments

4 Signature

Provider's name and credentials

Provider's telephone

Provider's fax

Provider's signature

Date