

DMension

P.O. Box 81460, Rochester, MI 48308-1460
Telephone: (877) 345-4774 Fax: (248) 844-8614

Date:
To:
Patient Name:

Requestor:
Fax Number:
I.D. Number:

Certificate of Medical Necessity (CMN) for Support Surfaces

Please answer all of the questions listed below for
Alternating Pressure Mattresses or Air Fluidized Beds Y for Yes
N for No
D for Does Not Apply

- 1. Is the patient's physician going to supervise the use of the device? Y N D
- 2. Is the patient bedridden or chair bound as a result of severely limited mobility? Y N D
- 3. Does the patient have coexisting pulmonary or cardiac disease? Y N D
- 4. Has a conservative treatment program been tried without success? Y N D
- 5. Was a comprehensive assessment performed after failure of conservative treatment? Y N D
- 6. Are open, moist dressings used for the treatment of the patient? Y N D
- 7. Is there a trained full-time caregiver to assist the patient and manage all aspects involved with the use of the bed? Y N D

8. Over the past months, the patient's ulcer(s) has/have; _____
1) Improved 2) Remained the same 3) Worsened

9. Provide the stage and size of each pressure ulcer necessitating the use of the overlay, mattress, or bed. If the patient is highly susceptible to decubitus ulcers, but currently has no ulcer present, place a "9" under ulcer #1

	Ulcer #1	Ulcer #2	Ulcer #3
Stage:	_____	_____	_____
Max. Length(cm)	_____	_____	_____
Max. Width (cm)	_____	_____	_____

Estimated Length of Need (in months): _____

Clinical Rationale _____

Contact Name: _____ **Phone Number:** _____

Physician Signature
(Stamps are not acceptable)

_____/_____/_____
Date