

NHIC

National Heritage Insurance Company
12545 Riata Vista Circle
Austin, TX 78727

FAX: (512) 514-4209

Date _____ PCN _____ Client Name _____
Provider Name _____ Provider Medicare # _____
Provider Phone # _____ Provider Fax # _____

HOSPITAL BED

Dear Provider:

Please provide the requested information to NHIC Home Health Services. This information is needed to process the hospital bed authorization request you submitted.

- What type of bed is client currently sleeping in? _____ Why is it not meeting his/her medical needs? _____
- Client height _____ Weight _____
- Client's medical needs/procedures: _____ G-tube feedings _____ Suctioning _____
Bipap/Cpap/Other (please describe) _____
- Client's condition and functional level _____

- Why will a regular child's crib, regular bed or hospital bed with rails not meet this client's medical needs? _____

- Anticipated length of time this client will require the requested item? Please address the growth potential of the equipment. _____

- Why is a total, or semi-electric bed necessary, versus a manual bed? _____

- The specific manufacture's information for the item being requested including: Manufacturer _____
_____ Model _____ Price _____
as well as all accessories with price _____
- Who lives with the client? _____

Please send the above medical documentation to NHIC/Home Health with a completed Title XIX form.