



CERTIFICATE OF MEDICAL NECESSITY - SUPPORT SURFACES

DEPARTMENT OF HUMAN SERVICES

MEDICAL SERVICES DIVISION

SFN 728 (8-2006)

SECTION A

| | |
|-------------------------|------------|
| Certification Date/Type | |
| Name | Patient ID |

SECTION B - Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.

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|---|---------------------|-----------|-----------|-----------|
| Estimated Length of Need (Number of Months) 1-99 (99 = LIFETIME) | | | | |
| 1. Is the patient highly susceptible to decubitus ulcers? | | | | |
| 2. Are you supervising the use of the device? | | | | |
| 3. Does the patient have coexisting pulmonary disease? | | | | |
| 4. Has a conservative treatment program been tried without success? | | | | |
| 5. Was a comprehensive assessment performed after failure of conservative treatment? | | | | |
| 6. Are open, moist dressings used for the treatment of the patient? | | | | |
| 7. Is there a trained full-time caregiver to assist the patient and manage all aspects involved with the use of the bed? | | | | |
| 8. 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. | | | | |
| | Pressure Ulcer | Ulcer # 1 | Ulcer # 2 | Ulcer # 3 |
| | Stage | | | |
| | Maximum Length (cm) | | | |
| | Maximum Width (cm) | | | |
| 9. Over the past month, the patient's ulcer(s) has/have | | | | |

SECTION C - Narrative Description

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| Narrative description of all items, accessories and options ordered. |
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SECTION D - Physician Signature/Date

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| Signature | Date | (Signature and Date Stamps are not acceptable) |
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