



**BlueCross BlueShield
of Alabama**

An Independent Licensee of the Blue Cross and Blue Shield Association.

DURABLE MEDICAL EQUIPMENT

Blue Cross and Blue Shield of Alabama
P.O. Box 362025
Birmingham, Alabama 35236-2025
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Check As Appropriate: DME OXYGEN IPPB GLUCOMETER
 CPAP BIPAP CERTIFICATION RECERTIFICATION

PATIENT INFORMATION COMPLETE ALL ITEMS PERTAINING TO THE PATIENT'S CONDITION AND EQUIPMENT

1. Patient's Name		2. Date Patient Last Seen by Doctor	3. Subscriber Number
4. Diagnosis			5. Prognosis <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
6. Estimated Number of Months Equipment Needed <i>(Do NOT put "INDEFINITE"; be specific)</i>		7. What Is The Patient's Condition Concerning Mobility a. Bed Confined? <input type="checkbox"/> No <input type="checkbox"/> Yes—Complete immediately below <input type="checkbox"/> 50% of the Time <input type="checkbox"/> 75% of the Time <input type="checkbox"/> 100% of the Time b. Room Confined? <input type="checkbox"/> No <input type="checkbox"/> Yes c. Wheelchair Confined? <input type="checkbox"/> No <input type="checkbox"/> Yes d. Ambulatory? <input type="checkbox"/> No <input type="checkbox"/> Yes—Complete immediately below <input type="checkbox"/> Assistance Not Required <input type="checkbox"/> Assisted by a Walker or Cane <input type="checkbox"/> Assisted by a Person e. Is Patient Disoriented? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Date Prescribed _____			
8. Rental Period This Certification Applies To <i>(Certification Length CANNOT Exceed 12 Months)</i>			
First Day (MM-DD-YYYY)	Last Day (MM-DD-YYYY)		
9. Supplier's Name, Street Address, City, State, ZIP Code, Telephone #			
10. Supplier's Provider Number		11. Requested HCPCS code (s)	

GENERAL EQUIPMENT SEE THE SECTIONS ON THE BACK OF THE FORM FOR OXYGEN AND IPPB

12. General Equipment Selected for Patient <input type="checkbox"/> a. Alternating P.P. & Pump <i>(Complete #15)</i> <input type="checkbox"/> b. Bed, Electric <i>(Complete #13 and # 14)</i> <input type="checkbox"/> c. Bed, Semi-electric <i>(Complete #13 and # 14)</i> <input type="checkbox"/> d. Bed, Standard <input type="checkbox"/> e. Bed, Variable Height <i>(Complete # 14)</i> <input type="checkbox"/> f. Cane or Quad Cane <input type="checkbox"/> g. Walker <input type="checkbox"/> With Wheels <input type="checkbox"/> h. Wheelchair <input type="checkbox"/> 1) Standard <input type="checkbox"/> 2) Electric <input type="checkbox"/> 3) Detachable Arms <input type="checkbox"/> 4) Leg Rests <input type="checkbox"/> 5) Special; Type: _____ <input type="checkbox"/> i. Commode, Bedside <input type="checkbox"/> j. Lift, Patient <input type="checkbox"/> k. Nebulizer, Hand-held <input type="checkbox"/> l. Nebulizer, Ultrasonic <input type="checkbox"/> m. Percussor <i>(Complete #16)</i> <input type="checkbox"/> n. Rails, Bedside <input type="checkbox"/> o. Suction Machine <input type="checkbox"/> p. Sitz Bath <input type="checkbox"/> q. Traction Equipment <input type="checkbox"/> r. Trapeze Bar <input type="checkbox"/> s. Other <i>(Describe)</i> _____	COMPLETE WHEN INDICATED IN QUESTION 12	
	13. Regarding Electric Beds, is the Patient able to work the controls and cause the adjustments? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	14. Does the Patient's condition require frequent changed in body position not feasible in an ordinary bed? <input type="checkbox"/> No <input type="checkbox"/> Yes; condition is:	
	15. Does the Patient now have or is the Patient susceptible to decubitus ulcers? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	16. a. Has the Patient been trained by a Therapist or Physician to use a powered percussor? <input type="checkbox"/> Yes <input type="checkbox"/> No b. Is there anyone else at the Patient's home who could administer manual therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	17. CPAP/BIPAP Date of sleep study: _____ Name of facility: _____ Respiratory disturbance index (RDI) preCPAP: _____ <input type="checkbox"/> CPAP pressures: _____ <input type="checkbox"/> BIPAP pressures: _____	
	18. If for recertification, has Patient demonstrated compliance in the use of this equipment? <input type="checkbox"/> Yes <input type="checkbox"/> No	

SEE REVERSE SIDE FOR SIGNATURE

