Tomorrow Health
Phone 1-844-402-4344
Fax 888-616-2361 | tomorrowhealth.com

◯ Standard Service (3-5 days) ◯ Expedited Service (1-3 days) ◯ Discharge Service
Date and time your patient will be discharged:

Hospital Beds

v2

1. Patient Information

First name*: _____ Last name*: _____

Address*: _____ City*: _____ State*: _____

Zip*: _____ Phone*: _____ Email: _____

Primary insurance carrier*: _____ Primary insurance member ID*: _____

Secondary insurance carrier: _____ Secondary insurance member ID: _____

Date of birth*: _____ Sex*: _____ Height*: _____ Weight*: _____

2. Clinical Details

Frequency of use*: _____ Length of need/refills*: _____

Diagnosis 1 (ICD-10)*:

◯ Bed confinement status (Z74.01) ◯ Chronic pain (G89.4) ◯ Congestive heart failure (I50.20) ◯ Other: _____

Diagnosis 2 (ICD-10): _____ **Diagnosis 3 (ICD-10):** _____

REQUIRED FOR COVERAGE: Upload face to face notes

3. Product Selection

Item	Accessory
◯ Semi-electric hospital bed with any type of side rails and a mattress - E0260	◯ Trapeze bars, attached to bed - E0910
◯ Heavy duty extra wide hospital bed with any type of side rails and a mattress - E0303 Patient weight >350 lbs <600 lbs	◯ Trapeze bars, free-standing - E0940
◯ Total electric hospital bed with any type of side rails and a mattress - E0265	◯ Trapeze bars, free-standing, heavy duty - E0912
	◯ Half length side rails - E0305

4. Notes

_____

_____

_____

5. Referring Provider Information

Referring provider name*: _____ NPI*: _____ Date*: _____

Referring provider signature*:

INTERNAL USE ONLY | TH rep sign here