WRITTEN ORDER PRIOR TO DELIVERY &
STATEMENT OF ORDERING PHYSICIAN

Group I Support Surface

Patient Name: _____ DOB: _____ HIC #: _____

Patient Address: _____ _____
Street City State Zip **EFFECTIVE DATE OF ORDER**

Detailed Written Order:

HCPCS Code	Product Description
□ **E0181**	**Powered Pressure Reducing Mattress Overlay/Pad, alternating with pump (Rental)**
□ **E0184**	**Dry Pressure Mattress (New Purchase)**
□ **E0185**	**Prevention Gel Pressure Mattress Pad (New Purchase)**

Information below may not be completed by the supplier or anyone in a financial relationship with the supplier.

In Response Box, circle: Y for YES, N for No, D for DOES NOT APPLY, unless otherwise noted.

A GROUP I Support Surface is covered if the patient meets:

a) Criteria 1, or
b) Criteria 2 or 3 <u>and</u> at least <u>one</u> of the bullet statements

Criteria 1	**Y N D**	**1) Is the patient completely immobile? (i.e. patient cannot make changes in body position without assistance.)**

OR

Criteria 2	**Y N D**	**2) Limited Mobility (i.e. patient cannot independently make changes in body position significant enough to alleviate pressure.)** **OR** **3) Any Pressure Ulcer on the Trunk or Pelvis**
AND		**At least 1 of the following must be <u>circled</u> to meet Criteria 2 or 3:** ▪ **Impaired nutritional status** ▪ **Altered sensory perception** ▪ **Fecal or urinary incontinence** ▪ **Compromised circulatory status**

► _____ **Estimated Length of Need (# months) 99 = Lifetime**

IF NONE OF THE ABOVE APPLIES, ATTACH SEPARATE SHEET DOCUMENTING MEDICAL NECESSITY FOR THE ITEM ORDERED

I certify that I am the physician identified below and that the information contained in this document is true, accurate and complete, to the best of my knowledge.

Date Signed: _____ **Physician Signature:** _____

Physician NPI: _____ **Physician Name:** _____

12/01/2010