

**R WRITTEN ORDER AND MEDICAL JUSTIFICATION
GROUP II SUPPORT SURFACE**

Date of Last Provider Visit _____

Supplier Name, Address, Telephone & NSC#:  915 30th Avenue Suite 106 Fairbanks, AK 99701 Phone: (907) 458-8912 Fax: (907) 458-8914 NSC#: 1267160002	Patient Name, Address, Telephone & Insurance ID#: () - Ins ID#: _____ Patient DOB: / / Sex: (M/F)
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GROUP II SUPPORT SURFACE:

Diagnosis and Code: _____
Length of Need (# of months) _____ 1-99 (99=life)
Patient Height: _____ ft. in. Weight: _____ lbs.

Pressure Reducing Mattress (E0277)
Note: Item requires prior authorization (PA) before dispensing

MEDICAL NECESSITY INFORMATION:

REQUIRED CRITERIA

1. The patient has multiple stage II pressure ulcers located on the trunk of pelvis which have failed to improve over the past month, during which time the beneficiary has been on a comprehensive ulcer treatment program including each of the following:

- Use of an appropriate group I support surface, and
- Regular assessment by a nurse, practitioner, or other licensed healthcare practitioner, and
- Appropriate turning and positioning, and
- Appropriate wound care, and
- Appropriate management of moisture/incontinence, and
- Nutritional assessment and intervention consistent with overall plan of care.

Patient must have a care plan that contains the above criteria (when applicable to patient's condition)

OR

MEDICAL NECESSITY INFORMATION:

REQUIRED CRITERIA

2. The patient has large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis
 Y N

OR

3. The patient had a myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis within the past 60 days (60 days from the date of surgery) and has been on a group II or group III support surface immediately prior to discharge from a hospital or nursing facility within the past 30 days.
 Y N

PROVIDER CERTIFICATION:

I, the patient's treating provider, certify the medical necessity of these items for this patient and maintain medical records reflecting the medical justification and care provided.

Provider's Signature Date

Provider's Name

NPI: _____ Telephone: _____