


**R WRITTEN ORDER AND MEDICAL JUSTIFICATION
TRAPEZE & BED SUPPORT SURFACES**

Date of Last Provider Visit _____

Supplier Name, Address, Telephone & NSC#:  4215 Credit Union Dr. Anchorage, AK 99503 Phone: (907) 274-0770 Fax: (907) 274-0773 NSC#: 1267160001	Patient Name, Address, Telephone & HIC#: () - HIC#: _____ Patient DOB: / / Sex: (M/F)
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An order was received on _____ for the services/equipment provided to the above named patient. In order to properly bill for the services/equipment provided we require a revised detailed written order. Please review and verify this information by completing any of the highlighted areas, and date and sign at the bottom. We suggest you keep a copy of this for your records. Prepared by: _____

BED SUPPORT SURFACES:

TRAPEZE:

Diagnosis and Code: _____

Date of Service: _____

Length of Need (# of months) _____ 1-99 (99=life)

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Length of Need (# of months) _____ 1-99 (99=life)

Patient Height: _____ ft. in. Weight: _____ lbs.

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- Alternating Pressure Pad System (Includes: APP Pump (E0181) and Pad (E0197))
- Dry Pressure Overlay (E0184)
- Gel Pressure Overlay (E0185)

- Trapeze Bar (E0910) up to 250lbs
- Trapeze Bar with Base (E0940) 251lbs or greater
- Bariatric Trapeze Bar (E0912) 250-1000lbs.

MEDICAL NECESSITY INFORMATION:

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REQUIRED CRITERIA

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1. The patient is completely immobile.
 Y N

OR
2. The patient has limited mobility i.e., patient cannot independently make changes in body position significant enough to alleviate pressure and at least one of conditions A-D below,
 Y N

OR
3. The patient has any stage pressure ulcer on the trunk or pelvis and at least one of conditions A-D below.
 Y N

OR
4. Does the patient have any of the following conditions?
 Impaired Nutritional Status
 Fecal or Urinary Incontinence
 Altered Sensory Perception
 Compromised Circulatory Status.

1. Does the patient need this device to sit up because of a respiratory condition?
 Y N

OR
2. Does the patient need this device to change body position for other medical reasons?
 Y N

OR
3. Does the patient need this device to get in or out of bed?
 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: _____