℞ WRITTEN ORDER AND MEDICAL JUSTIFICATION
TRAPEZE & BED SUPPORT SURFACES

Date of Last Provider Visit_____

Supplier Name, Address, Telephone & NSC#:	**Patient Name, Address, Telephone & HIC#:**
PROCARE HOME MEDICAL **4215 Credit Union Dr.** **Anchorage, AK 99503** **Phone: (907) 274-0770 Fax: (907) 274-0773** **NSC#: 1267160001**	**( ) - HIC#:** **Patient DOB: / / Sex: (M/F)**

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:

Date of Service:_____

Diagnosis and Code:_____

Length of Need (# of months)_____1-99 (99=life)

Patient Height:_____ft. in. Weight:_____lbs.

- ☐ Alternating Pressure Pad System (Includes: APP Pump (E0181) and Pad (E0197)
- ☐ Egg Create Overlay (E0199)
- ☐ Dry Pressure Overlay (E0184)
- ☐ Gel Pressure Overlay (E0185)

MEDICAL NECESSITY INFORMATION:

REQUIRED CRITERIA

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

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

TRAPEZE:

Date of Service: _____

Diagnosis and Code: _____

Length of Need (# of months)_____1-99 (99=life)

Patient Height:_____ft. in. Weight:_____lbs.

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

MEDICAL NECESSITY INFORMATION:

REQUIRED CRITERIA

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: _____

Updated 12.26.19