℞ WRITTEN ORDER AND MEDICAL JUSTIFICATION
TRAPEZE & BED SUPPORT SURFACES

Date of Last Provider Visit_____

Supplier Name, Address, Telephone & NSC#:	**Patient Name, Address, Telephone & Insurance ID #:**
PROCARE HOME MEDICAL **915 30th Avenue Suite 106** **Fair**banks**, AK 99701** **Phone: (907)** 458-8912 **Fax: (907)** 458-8914 **NSC#: 1267160002**	**( ) - Ins ID #:** **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:

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)

☐ 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 on question 4 below,
   ☐ Y ☐ N

OR

3. The patient has any stage pressure ulcer on the trunk or pelvis and at least one of conditions on question 4 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 12-28-20