℞ 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)**

We have been asked to provide the following equipment to the patient named above. 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.

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)
☐ Trapeze Bar with Base (E0940)

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: _____