


**GROUP I SUPPORT SURFACE STANDARD WRITTEN ORDER**

 <p style="text-align: center;">Please fax to:  <b>Anchorage (907) 274-0773</b>  <b>Fairbanks (907) 458-8914</b>  <b>Soldotna (907) 260-3757</b>  <b>Wasilla (907) 357-7883</b>                  or email to:  <b>dme@procarehm.com</b></p>	<p><b>Patient Name, Address, Telephone &amp; Insurance ID #:</b></p> <hr/> <p><b>Phone:</b> _____ <b>Ins ID #:</b> _____</p> <p><b>Patient DOB:</b> _____ <b>Sex:</b> _____ <b>(M/F)</b></p>
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Refer to Group I Support Surface coverage criteria sheets for all required documentation.

Date of Last Visit: \_\_\_\_\_

**GROUP 1 SUPPORT SURFACE:**

Diagnosis and Code: \_\_\_\_\_ Patient Height: \_\_\_\_\_ in. Weight: \_\_\_\_\_ lbs.

Length of Need (# of months) \_\_\_\_\_ 1-99 (99=life) Order Date: \_\_\_\_\_

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

**MEDICAL NECESSITY INFORMATION:**

1. The patient is completely immobile - i.e., patient cannot make changes in body position without assistance      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 the conditions in question 4       Y       N  
     OR
3. Does the patient have any stage pressure ulcer on the trunk of pelvis and at least one of the conditions in question 4       Y       N
4. Does the patient have any of the following conditions?
  - Impaired Nutritional Status       Altered Sensory Perception
  - Compromised Circulatory Status       Fecal or Urinary Incontinence

**Care Plan** should include the following in the patient's medical records established by the treating practitioner or home care nurse:

- ✓ Prevention and/or management of pressure ulcer education to the patient and caregiver
- ✓ Regular assessment by a nurse, treating practitioner, or other licensed healthcare practitioner
- ✓ Appropriate turning and positioning
- ✓ Appropriate wound care (for a stage II III or IV ulcer)
- ✓ Appropriate management of moisture/incontinence
- ✓ Nutritional assessment and intervention consistent with the overall plan of care

**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 \_\_\_\_\_ NPI: \_\_\_\_\_

Provider's Name: \_\_\_\_\_ Telephone: \_\_\_\_\_