


GROUP II SUPPORT SURFACE STANDARD WRITTEN ORDER

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|  <p> 4215 Credit Union Dr. Anchorage, AK 99503 Phone: (907) 274-0770 Fax: (907) 274-0773 NSC#: 1267160001 </p> | <p>Patient Name, Address, Telephone & Insurance ID#:</p> <p>() - Ins ID#: _____</p> <p>Patient DOB: / / Sex: (M/F)</p> |
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Please fax orders long with required documentation to (907) 274-0773 or email to dme@procarehm.com
Refer to Group II Support Surface coverage criteria sheet for all required documentation.

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| GROUP II SUPPORT SURFACE: |
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Diagnosis and Code: _____ Patient Height: _____ in. Weight: _____ lbs.
 Length of Need (# of months) _____ 1-99 (99=life) Order Date: _____

Pressure Reducing Mattress (E0277)
 Note: Item requires prior authorization (PA) before dispensing

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| MEDICAL NECESSITY INFORMATION: Must also be supported in the medical records, if applicable. |
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1. The patient has multiple stage II pressure ulcers located on the trunk of pelvis which have failed to improve over the past month, during which time the beneficiary has been on a comprehensive ulcer treatment program including each of the following:
 - Use of an appropriate group I support surface
 - Regular assessment by a nurse, practitioner, or other licensed healthcare practitioner
 - Appropriate turning and positioning
 - Appropriate wound care
 - Appropriate management of moisture/incontinence
 - Nutritional assessment and intervention consistent with overall plan of care

Patient must have a care plan that contains the above criteria (when applicable to patient's condition)

OR
2. The patient has large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis Y N

OR

3. The patient had a myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis within the past 60 days (60 days from the date of surgery) and has been on a Group II or Group III Support Surface immediately prior to discharge from a hospital or nursing facility within the past 30 days. Y N

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| 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: _____ |