GROUP II **SUPPORT SURFACE STANDARD WRITTEN ORDER**

PROCARE HOME MEDICAL

Please fax to:
Anchorage (907) 274-0773
Fairbanks (907) 458-8914
Soldotna (907) 260-3757
Wasilla (907) 357-7883
or email to:
dme@procarehm.com

Patient Name, Address, Telephone & Insurance ID#:

Phone: **Ins ID#:**

Patient DOB: **Sex:** **(M/F)**

Refer to Group II Support Surface coverage criteria sheet for all required documention.

GROUP II SUPPORT SURFACE:

Date of Last Visit: _____ Order Date: _____

Diagnosis and Code: _____

Length of Need (# of months)_____1-99 (99=life) Patient Height:_____in.Weight:_____lbs.

Pressure Reducing Mattress (E0277)

Note: Item requires prior authorization (PA) before dispensing

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:_____

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