

GROUP I SUPPORT SURFACE STANDARD WRITTEN ORDER



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 I Support Surface coverage criteria sheets for all required documentation.

GROUP 1 SUPPORT SURFACE:

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

Diagnosis and Code: \_\_\_\_\_

Length of Need (# of months) \_\_\_\_\_ 1-99 (99=life) Patient Height: \_\_\_\_\_ in. Weight: \_\_\_\_\_ lbs.

Alternating Pressure Pad System (E0181)

Gel Pressure Overlay (E0185)

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