GROUP I **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 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: _____