Statement of Ordering Provider and Written Order Prior to delivery
Group I Support Surfaces

Name: _____ D/O/B: _____ Gender: M☐F☐HT: ___ WT: ___

Address: _____

	HCPCS	Product Description	Supplier Charge	Insurance Allowable
☐	E0181	Powered Pressure-Reducing Overlay/Pad	_____	_____
☐	E0185	Gel or Gel-Like Pressure pad/Overlay	_____	_____
☐	E0197	Air Pressure Pad	_____	_____
☐	E0184	Dry Pressure Mattress	_____	_____
☐	E0199	Dry Pressure Pad	_____	_____

Diagnosis Code(s): _____ _____ _____ _____

The information below may not be completed by the supplier or anyone in a financial relationship with the supplier

I certify that the following statements are true:

Indicate which of the following conditions describe the patient. **Check all that apply:**

☐ 1) Completely immobile i.e. Patient cannot make changes in body position significant enough to alleviate pressure.

☐ 2) Limited mobility i.e. Patient cannot independently make changes in body position significant enough to alleviate pressure.

☐ 3) Any pressure ulcer on the trunk or pelvis.

☐ 4) Impaired nutritional status.

☐ 5) Fecal or urinary incontinence.

☐ 6) Altered sensory perception.

☐ 7) Compromised circulatory status.

If none of the above apply, attach a separate sheet documenting medical necessity for the item ordered.

Estimated length of need (# of months) _____ (99=lifetime)

Physician Signature: _____ **Date:** _____

Physician: _____ NPI: ___ _____ Phone: _____ Fax: _____

Address: _____