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

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

Address: _____

	HCPCS	Product Description	Supplier Charge	Insurance Allowable
☐	E0277	Powered Pressure Air Mattress / Low Air Loss Mattress	_____	_____

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 answers are true:

Circle **Y** for YES **N** for NO and **D** for Does not apply, unless otherwise noted.:

Y N D 1) Does the patient have multiple stage II pressure ulcers on the trunk or pelvis?

Y N D 2) Has the patient been on a comprehensive ulcer treatment program for at least the past month which has included the use of an alternating pressure or low air loss overlay which is less than 3.5 inches, or a non-powered pressure reducing overlay or mattress?

1 2 3 3) Over the past month, the patient's ulcer(s) has/have: 1) Improved 2) Remained the same 3) Worsened?

Y N D 4) Does the patient have large or multiple stage III or IV pressure ulcer(S) on the trunk or pelvis?

Y N D 5) Has the patient had a recent (within the past 60 days) myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis? If yes, give the date of surgery: _____

Y N D 6) Was the patient on an alternating pressure or low air loss mattress or bed or on an air fluidized bed immediately prior to a recent (within the past 30 days) discharge from a hospital or nursing facility?

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: _____