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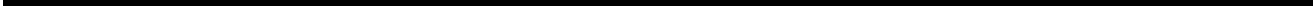
**Statement of Ordering Physician
Group 1 Support Surfaces**

Patients Name: _____

HIC#: _____

Cost Information:

<u>Description</u>	<u>Procedure Code</u>	<u>Suppliers Charge</u>	<u>Medicare fee schedule allowance</u>
Gel Mattress Overlay	EO185	\$471.80	\$285.18



THE INFORMATION BELOW MAY NOT BE COMPLETED BY THE SUPPLIER OR ANYONE IN A FINANCIAL RELATIONSHIP WITH THE SUPPLIER.

Diagnosis: _____

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

- 1) Completely immobile - i.e. patient cannot make changes in body position without assistance.
- 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.

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

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

Physicians Name: _____

Physicians NPI: _____

Physicians Signature: _____

Date Ordered: _____