8703-E N. University St
Peoria, IL 61615
Phone: 309-693-4459
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Statement of Ordering Physician
Group 2 Support Surfaces

Patients Name: ______________________ HIC #: ____________

Address: ______________________

City: ____________ State: ____________ Zip: ____________

Cost Information:

Description	Procedure Code	Suppliers Charge	Medicare fee schedule allowance
Pwrd Pressure Reducing Air Mattress	E0277	$1055.20/month	$636.64

Physician name: ______________________ Physician NPI: ____________
(Printed or typed)

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

DIAGNOSIS CODES: 1 ________ 2 ________ 3 ________ 4 ________

A Group 2 support surface is covered if the patient meets:
a.) Criterion 1 and 2 and 3, or b.) Criterion 4, or c.) Criterion 5 and 6

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

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 a nonpowered pressure reducing overlay or mattress or an alternating pressure of low air loss overlay?

A B C 3. Over the past month, the patient's ulcer(s) has/have:
A. Remained the same B. Worsened C. Improved
**** If improved, patient must qualify under criterion 4 or 5 and 6 ****

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

Y N D 5. Has the patient had an 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 prior to a recent (within the past 30 days) discharged from a hospital or nursing facility?

(D) Does not apply.

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

Physician's Signature: ______________________ Date Ordered: ____________