HOSPITAL BED, GEL OVERLAY, LOW AIR LOSS MATTRESS

WRITTEN ORDER PRIOR TO DELIVERY **FAX: 312-738-2395** **PHONE: 312-738-2330**

Patient Name:_____ Patient DOB:_____

Patient Address:_____ City:_____ SS#/ HICN:_____

State:_____ Zip Code:_____ Patient Telephone #:_____

Patient HEIGHT:_____Patient WEIGHT:_____ Seated HIP MEASUREMENT:_____

ORDER DATE : _____

DATE PT. LAST SEEN_____ D/C DT_____

Diagnosis: _____
(ICD-10 CODES) _____
Prognosis _____

☐ **Description:** ***SEMI ELECTRIC HOSPITAL BED*** WITHOUT RAILS OR WITH RAILS, WITHOUT MATTRESS OR WITH MATTRESS
CODE: E0294 / E0295 E0260/E0261 **Quantity:** 1

NO RAILS ☐ *FULL RAILS* ☐ *HALF RAILS* ☐ **Quantity:** 1

*Indicate if one or more of the following conditions describes the patient (**CHECK**) all that apply:*

☐ **1.** Patient has medical condition which requires positioning of body in ways not feasible with an ordinary bed.

☐ **2**. Patient requires positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain

☐ **3.** Patient requires the head of the bed to be elevated more than 30 degrees most of the time due to CHF, COPD, or problems with aspiration.

☐ **4**. Patient requires traction equipment, which can only be attached to a hospital bed.

-AND-

Y ☐ **N** ☐ Does the pt. require frequent changes in body position and/or has an immediate need for a change in body position?

MEDICARE DOES NOT COVER FULL ELECTRIC HOSPITAL BEDS

☐ **Description: GEL / FOAM OVERLAY MATTRESS** **Code:** E0185 **Quantity: 1**

Indicate which of the following conditions describes the patients (CHECK ALL THAT APPLY)

☐ **1:** *COMPLETELY IMMOBILE*
☐ **2:** *LIMITED MOBILITY*
☐ **3:** *ANY STAGE PRESSURE ULCER ON TRUNK OR PELVIS*
☐ **4:** *IMPAIRED NUTRITIONAL STATUS*
☐ **5:** *FECAL OR URINARY INCONTINENCE*
☐ **6:** *ALTERED SENSORY PERCEPTION*
☐ **7:** *COMPROMISED CIRCULATORY STATUS*

☐ **Description: LOW AIR LOSS MATTRESS W/ ALTERNATING PRESSURE THERAPY** *Code: E0277* **Quantity: 1**

(CIRCLE) **Y** for Yes, **N** for No, **D** for Does Not Apply, unless otherwise noted:

Y N D **1.** Does the patient have multiple stage II pressure ulcers on 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 pad 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 month, the patient's ulcer(s) 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 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 please give the date of surgery: _____

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

Wound 1	**Wound 2**	**Wound 3**	**Wound 4**
Stage: I II III IV	**Stage: I II III IV**	**Stage: I II III IV**	**Stage: I II III IV**
L____W____D____	**L____W____D____**	**L____W____D____**	**L____W____D____**
Location: _____	**Location: _____**	**Location: _____**	**Location: _____**

I, the undersigned, certify that the above prescribed equipment/supplies is medically necessary as part of my treatment for this patient. In my opinion, the equipment prescribed is reasonable and necessary for accepted standards of medical practice and treatment of this patient's condition and has not been prescribed as "convenience equipment."

Physician Name: _____ Physician Telephone # _____

Physician Address: _____ City:_____ State: _____ Zip_____

Physician Signature: _____NPI#:_____Date:_____

Note: Please maintain a copy of the Written Order, which must be kept on file for 7 years or longer if, required by state law.