520 Boston Post Rd, Old Saybrook, CT 06475
860-388-1437 FAX: 860-388-0368
www.northeastmedicalproducts.com
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INNOVA MEDICAL PRODUCTS

GROUP I SUPPORT SURFACE PRESCRIPTION FORM

Patient Name _____ Phone _____

Address _____

Email _____

DOB _____ Height _____ Weight _____

Diagnosis codes _____ Length of Need _____

Alternate Contact Name _____ Relationship _____ Phone _____

Equipment ordered:

_____ E0181 Alternating Pressure Pad and Pump

_____ E0185 Gel or Gel Like Pressure Pad for Standard Mattress

Coverage Questions:

Y N The patient is completely immobile – i.e., patient cannot make changes in body position without assistance.

Y N The patient has limited mobility – i.e., patient cannot independently make changes in body position significant enough to alleviate pressure and at least one of conditions A-D below (Please select condition(s) below)

Y N The patient has any stage pressure ulcer on the trunk or pelvis and at least one of conditions A-D below (Please select condition(s) below)

A. Impaired nutritional status
B. Fecal or urinary incontinence
C. Altered sensory perception
D. Compromised circulatory status

RELATED CLINICAL INFORMATION (Requires Face-To-Face documentation)

A beneficiary needing a pressure reducing support surface should have a care plan which has been established by the beneficiary's treating practitioner or home care nurse, which is documented in the beneficiary's medical records, and which generally should include the following:

1. Education of the beneficiary and caregiver on the prevention and/or management of pressure ulcers
2. Regular assessment by a nurse, treating practitioner, or other licensed healthcare practitioner
3. Appropriate turning and positioning
4. Appropriate wound care (for a stage 2, 3 or 4 ulcer)
5. Appropriate management of moisture/incontinence
6. Nutritional assessment and intervention consistent with the overall plan of care

Physician Name _____ NPI _____

Address _____

Phone _____ Fax _____

_____ _____

Physician Signature Date