DW MEDICAL SUPPLY ,INC
1524 Centinela Ave
Inglewood CA 90302
Ph: (310) 330-0162 Fax : (310) 330-0199

PRESSURE REDUCING SUPPORT SURFACES-GROUP 1

Statement of Ordering Physician: Group 1 Support Surfaces (E0185)

Patient name: _____

Medicare # _____ DOB: _____

Cost information (to be completed by the supplier):

Supplier's charge _____$350_____

Medicare fee schedule allowance _____$335.85_____

The information below may not be completed by the supplier or anyone in a financial relationship with the supplier.

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

1) Completely immobile- 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 for the item ordered.

Physician name: _____NPI #_____

Physician signature:_____ Date _____

A group 1 mattress gel overlay or mattress (E0180-E0189, E0196-E0199, and A4640) is covered if the patient meets:

a) Criterion 1, or

b) Criteria 2 or 3 and at least one of criteria 4-7.

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 stage pressure ulcer on the trunk or pelvis.

4) Impaired nutritional status.

5) Fecal or urinary incontinence.

6) Altered sensory perception.

7) Compromised circulatory status.