Patient Information

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_Zip\_\_\_\_\_\_

Primary Insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Discharge Date\_\_\_\_\_\_\_\_\_\_\_\_ Height\_\_\_\_\_\_\_Weight\_\_\_\_\_\_Diagnonsis Codes\_\_\_\_\_\_\_\_\_\_\_\_\_Length of Need(# of Months)\_\_\_\_\_\_\_\_1-99 (99=Lifetime)

**GROUP 1 SUPPORT SURFACE**

| * Alternating Pressure Pad System (Includes: APP Pump (E0181) and Pad (E0197) * Gel Pressure Overlay (E0185) |
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MEDICAL NECESSITY INFORMATION: Must be supported in the medical records, if applicable

1. The patient is completely immobile - i.e: The patient cannot make changes in body position without assistance .  
 \_\_\_\_YES\_\_\_\_NO

**OR**

2. The patient has limited mobility i.e: The patient cannot independently make changes in body position significant enough to alleviate pressure and at least one of the conditions in question 4. \_\_\_\_YES\_\_\_\_\_NO

**OR**

3. Does the patient have any stage pressure ulcer on the trunk of the pelvis and at least one of the conditions in question 4. \_\_\_\_\_YES\_\_\_\_\_NO

4. Does the patient have any of the following conditions?

\_\_\_Impaired Nutritional Status \_\_\_Altered Sensory Perception

\_\_\_Compromised Circulatory Status \_\_\_Fecal or Urinary Incontinence

Care Plan should include the following in the patient's medical records established by the treating practitioner or home care nurse:

* Prevention and/or management of pressure ulcer education to the patient and caregiver
* Regular assessment by a nurse, treating practitioner, or other licensed healthcare practitioner
* Appropriate turning and positioning
* Appropriate wound care (for a stage II III or IV ulcer)
* Appropriate management of moisture/incontinence
* Nutritional assessment and intervention consistent with the overall plan of care

| PROVIDER CERTIFICATION:  *I, the patient's treating provider, certify the medical necessity of these items for this patient and maintain medical records reflecting the medical justification and care provided.*  Provider Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_NPI:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Provider Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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