

Statement of Ordering Physician Group I Support Surface / Hospital Bed



PLEASE PRINT ALL INFORMATION CLEARLY.

Patient Name _____ Date of Birth _____ Order Date _____

ID# _____ Phone Number _____

Address _____ City _____ State _____ Zip Code _____

Product: **NWC400 Gel/Foam Overlay** HCPC Code: **E0185** Charge: **\$320/each** Allowable: **\$320/each approx.***

Product: **Semi-Electric Bed Frame With Mattress** HCPC Code: **E0260** Charge: **\$180/month** Allowable: **\$127/month approx.***

* Varies by state.

Information in Sections A – C may NOT be completed by the supplier of the equipment. PLEASE COMPLETE ALL SECTIONS BELOW.

A. HOSPITAL BED/ACCESSORIES (Answer all 1, 3-7.)

1. Does the patient require positioning of the body in ways not feasible with an ordinary bed due to a medical condition that is expected to last at least one month? Yes No D

3. Does the patient require, for the alleviation of pain, positioning of the body in ways not feasible with an ordinary bed? Yes No D

4. Does the patient require the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease or aspiration? Yes No D

5. Does the patient require traction that can only be attached to a hospital bed? Yes No D

6. Does the patient require a bed height different than a fixed-height hospital bed to permit transfers to chair, wheelchair or standing position? Yes No D

7. Does the patient require frequent changes in body position and/or have an immediate need for a change in body position? Yes No D

Name and title of person answering questions if other than physician _____

B. GROUP I SUPPORT SURFACE (Answer all 1-7.)

1. Completely immobile — patient cannot make changes in body position. Yes No

2. Limited mobility — patient cannot independently make changes in body position significant enough to alleviate pressure. Yes No

3. Any pressure ulcer on the trunk or pelvis (includes stage I). Yes No

4. Impaired nutritional status. Yes No

5. Fecal or urinary incontinence. Yes No

6. Altered sensory perception. Yes No

7. Compromised circulatory status. Yes No

Name and title of person answering questions if other than physician _____

C. PHYSICIAN CERTIFICATION (Complete all blanks in this section.)

Estimated length of need (99 months = lifetime) _____ Primary/Secondary diagnoses _____

Physician name (print) _____ NPI# _____

Physician signature _____ Date signed _____

SIGNATURE AND DATE MUST BE HANDWRITTEN, NO STAMPS.

PLEASE FAX TO NATIONAL WOUND CARE AT 1-800-808-8768. Mail original to 2906 W. Clark Road, Champaign, IL 61822.
800-982-1835 nationalwound.com