CERTIFICATE OF MEDICAL NECESSITY

Group 2 Support Surfaces

Cert Type: **Eff. Date:**

Patient, Address, Phone

Provider Name, Address, Phone and Fax Number, NSC Numbe

Fax:

NSC#:

Account No.:

Patient DOB: **Sex:** **HT:** **WT:**

Physician's License #: **UPIN#:**

Physician

Diagnosis Codes & Descriptions

Primary insurance:

Secondary insurance:

Type of equipment ordered:

HCPCs:

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

Circle Y for yes, N for no or D for does not apply, unless otherwise noted.

Y N D 1) Does the patient have multiple stage II pressure ulcers on the 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 an alternating pressure 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 past month, the patient's ulcer(s) has/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 the 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, give date of surgery: _____/_____/_____

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

Duration of Need: _____ 1-99 (99=Lifetime)

Physician Attestation

I certify that I am the physician identified above. I have recieved the information of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information on this form is true, accurate and complete to the best of my knowledge, and I understand that any falsification, omission or concealment of material fact in that information may subject me to criminal or civil liability.

PHYSICIAN'S SIGNATURE _____ DATE _____ /_____ /_____ (*DO NOT STAMP*)