HANDI MEDICAL SUPPLY

Standard Written Order: Group I Support Surface

Prescriber Information

Clinic/Location Name:
Prescriber Name:
Prescriber Address:
Prescriber City State Zip:
Prescriber Phone:
Prescriber Fax:
Prescriber NPI:

Patient Information

Patient Name:
Patient Address:
Patient City State Zip:
Phone:
DOB:
Primary Insurance:
Handi Customer Number:

Diagnosis (ICD-10)

HCPC	Description	Dispensing Qty
☐ E0181	Powered pressure reducing mattress overlay/pad, alternating, with pump, includes heavy duty	1 each every 5 years
☐ E0182	Pump for alternating pressure pad, for replacement only	1 each every 5 years
☐ E0184	Dry pressure mattress (high density foam)	1 each every 5 years
☐ E0185	Gel or gel-like pressure pad for mattress, standard length & width	1 each every 5 years
☐ E0197	Air pressure pad for mattress, standard mattress length and width	1 each every 5 years

1. Ordered Date: _____ **2. Length of Need:** _____

Leaving blank presumes Lifetime (99 months)

3. Please complete the following questions:

A. ☐ **YES** ☐ **NO** Is your patient completely immobile (i.e., cannot make changes in body position without assistance)? **OR**

B. ☐ **YES** ☐ **NO** Does your patient have limited mobility (i.e., beneficiary cannot independently make changes in body position significant enough to alleviate pressure)? **OR**

C. ☐ **YES** ☐ **NO** Does your patient have a pressure ulcer on the trunk or pelvis?

If B or C is YES, please answer the following:

☐ **YES** ☐ **NO** Does your patient have an impaired nutritional status?

☐ **YES** ☐ **NO** Does your patient have fecal or urinary incontinence?

☐ **YES** ☐ **NO** Does your patient have an altered sensory perception?

☐ **YES** ☐ **NO** Does your patient have a compromised circulatory status?

4. Please attach medical records supporting necessity of the above ordered item(s).

5. _____ _____

Physician/NP/PA/Medical Practitioner Signature — Date

: Signer must match Prescriber Information at the top of this form, or be updated below

Print New Prescriber Name: _____ NPI: _____

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