

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:
Homecare Agency:

Diagnosis (ICD-10) *select all that apply*

| HCPC | Description | Dispensing Qty |
|-------------|--|-----------------------|
| E0277 | POWERED PRESSURE-REDUCING AIR MATTRESS | 1 each every 5 years |
| E0373 | NONPOWERED ADVANCED PRESSURE REDUCING MATTRESS | 1 each every 5 years |
| E0371 | NONPOWERED ADVANCED PRESSURE REDUCING OVERLAY | 1 each every 5 years |

1. **Ordered Date:** _____ 2. **Length of Need:** _____
Leaving blank presumes Lifetime (99 months)

3. **Please attach medical records, including wound measurements, supporting the necessity of the above ordered item(s).**

4. **Additional comments or Diagnosis Codes not listed above:**

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: _____