

SUPPORT SURFACE, HOSPITAL BED & WHEELCHAIR REFERRAL FORM

Phone: _____

To place an order, please complete and FAX to:

For use in AZ and other States as applicable

Patient Name: _____

Date of Birth: _____

RX Date: _____

Diagnosis: *Refer to ICD-10 listing all codes*

- | | |
|--|---|
| <input type="checkbox"/> COPD (J44.9) | <input type="checkbox"/> Extrinsic Asthma (J45.20) |
| <input type="checkbox"/> Chronic Bronchitis (J42) | <input type="checkbox"/> Chronic Obstructive Asthma (J44.9) |
| <input type="checkbox"/> Acute Bronchiolitis (J20.9) | <input type="checkbox"/> Emphysema (J43.9) |
| <input type="checkbox"/> CHF (I50.9) | <input type="checkbox"/> OSA (G47.33) |

* *Support surfaces require a pressure ulcer diagnoses & stage (I-IV) of ulcer*

Pressure Ulcer: _____
Stage of Ulcer: _____

Other : _____

Length of Need: _____ (If lifetime, use 99) Height _____ Weight: _____

Wheelchairs

- | | | |
|--|---|---|
| <input type="checkbox"/> Standard Wheelchair | <input type="checkbox"/> Lightweight Wheelchair | <input type="checkbox"/> Heavy Duty Wheelchair |
| <input type="checkbox"/> Extra Heavy Duty Wheelchair | <input type="checkbox"/> Transport Chair | <input type="checkbox"/> Fully Reclining Wheelchair |
| <input type="checkbox"/> Swing Away Leg Rests | <input type="checkbox"/> Elevating Leg Rests | |

Other Wheelchair Accessory _____

Basic Wheelchair Cushion Low Pressure Wheelchair Cushion

Hospital Beds

Semi Electric Hospital Bed Fixed Height Hospital Bed Bariatric Hospital Bed

Group I Mattress/Overlay

Alternating Pressure Pad E0181 Gel Mattress Pad Overlay E0185 Egg Crate Mattress

Group II Mattress/Overlay

Low Air Loss Mattress E0277 Other _____

Comments/Other Orders:

Please provide face-to-face chart notes that support medical necessity with the order

I hereby certify that the services are medically necessary and are authorized by me. The patient is under my care and is in need of the services listed.

Physician's Printed Name: _____

NPI: _____

Fax: _____

Physician's Signature: _____

Signature Date: _____

Medicare requires the Signature and Signature Date be completed by a PECOS enrolled MD, DO, PA, NP, or CNS