## 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 a  COPD (J44.9) Chronic Bronchitis (J42) Acute Bronchiolitis (J20.9) CHF (I50.9) Other:	all codes  Extrinsic Asthma (J45.20) Chronic Obstructive Asthma (J44.9) Emphysema (J43.9) OSA (G47.33)	* Support surfaces require a pressure ulcer diagnoses & stage (I–IV) of ulcer  Pressure Ulcer: Stage of Ulcer:
Length of Need:(If lifetime, use 99) Height Weight:		
Wheelchairs		
<ul><li>☐ Standard Wheelchair</li><li>☐ Extra Heavy Duty Wheelchair</li><li>☐ Swing Away Leg Rests</li></ul>	<ul><li>☐ Lightweight Wheelchair</li><li>☐ Transport Chair</li><li>☐ Elevating Leg Rests</li></ul>	☐ Heavy Duty Wheelchair ☐ Fully Reclining Wheelchair
Other Wheelchair Accessory		
☐ Basic Wheelchair Cushion	Low Pressure Wheelchair Cushic	on
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	5 ☐ Egg Crate Mattress
Group II Mattress/Overlay		
☐ Low Air Loss Mattress E0277	☐ Other	
Comments/Other Orders:		
Please provide face-to-face chart notes	s that support medical necessity with the	e 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: