

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:

- | | | |
|--|---|--|
| <input type="checkbox"/> COPD (J44.9) | <input type="checkbox"/> Extrinsic Asthma (J45.20) | * <i>Support surfaces require a pressure ulcer diagnoses & stage (I-IV) of ulcer</i> |
| <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) | |
| <input type="checkbox"/> Other : _____ | | |
- Pressure Ulcer: _____
Stage of Ulcer: _____

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 | |
| <input type="checkbox"/> Other Wheelchair Accessory _____ | | |
| <input type="checkbox"/> Basic Wheelchair Cushion | <input type="checkbox"/> Low Pressure Wheelchair Cushion | |

Hospital Beds

- | | | |
|---|--|---|
| <input type="checkbox"/> Semi Electric Hospital Bed | <input type="checkbox"/> Fixed Height Hospital Bed | <input type="checkbox"/> 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