To: Health Aid of Ohio
Attn: **CMN Dept.**
Fax: 216-252-4930
Phone: 216-252-3900

Statement of Ordering Physician
Group 1 Support Surfaces

Patient name: ____

Patient address: ____

HIC #: ____

Diagnosis: ____

Cost information (to be completed by the supplier):

Supplier Charge: ____________ Medicare fee schedule allowance: ________________

Product (check one):

- ☐ **Waffle Overlay**
- ☐ **Alternating pressure pad w/ pump**
- ☐ **Foam replacement**
- ☐ **Geo Mattress**
- ☐ **Gel foam overlay**
- ☐ **Other (specify):** ______________________

Circle Y for Yes, N for No, D for Does not apply, unless otherwise noted to describe the patient:

1) Y N D Completely immobile? – i.e. patient cannot make changes in body position without assistance.
2) Y N D Limited mobility? – i.e. patient cannot independently make changes in body position significant enough to alleviate pressure.
3) Y N D Any pressure ulcer on the trunk or pelvis?
   If YES: Stage______________ Size______________________________
4) Y N D Impaired nutritional status?
5) Y N D Fecal or urinary incontinence?
6) Y N D Altered sensory perception?
7) Y N D Comprised circulatory status?
8) Y N D Are you supervising the use of this device?
9) Y N D Is there a trained full-time caregiver to assist and manage all aspects involved with the use of the mattress?

If none of the above apply, attach a separate sheet documenting medical necessity for the item ordered.

Estimated length of need (# of months): ____________________________ (99=lifetime)

Date of last physician exam that established equipment needs: ________________________

Physician name (printed or typed): ______________________________________

Physician signature: _________________________________**Date Signed**: ______________________

Physician NPI: ____

Physician Address: ____