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

Statement of Ordering Physician
Group 2 Support Surfaces

Patient name: _____

Patient address: _____

HIC #: _____ Diagnosis: _____

Cost information (to be completed by the supplier):
Supplier Charge: _____ Medicare fee schedule allowance: _____

Model -Description:

☐ **ROHO Select Air E0277** ☐ **Sunflower Sapphire E0277** ☐ **ROHO Dry Floatation E0371**

The information below may not be completed by the supplier or anyone in a financial relationship with the supplier:

Circle Y for Yes, N for No, D for Does not apply, unless otherwise noted.

1. Y N D Does the patient have multiple stage II pressure ulcers on the trunk or pelvis?

2. Y N D Has the patient been on a comprehensive ulcer treatment program for at least the past month which has included the use of an alternating pressure or low air loss overlay which is less than 3.5 inches, or a nonpowered pressure reducing overlay or mattress?

3. 1 2 3 Over the past month, the patient's ulcer(s) has/have: 1) Improved 2) Remained the same 3) Worsened?

4. Y N D Does the patient have large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis?
If YES, give Size_____

5. Y N D Has the patient had a recent (within the past 60 days) myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis?
If yes, give date of surgery: _____

6. Y N D Was the patient on an alternating pressure or low air loss mattress or bed or an air fluidized bed immediately prior to a recent (within the past 30 days) discharge from a hospital or nursing facility?

7. Y N D Are you supervising the use of this device?

8. Y N D Is there a full-time caregiver to assist and manage all aspects involved with the use of this mattress?

Please attach all chart notes that pertain to his or her wound treatment and need for support surface.

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: _____