Statement of Ordering Physician  
Group 1 Support Surfaces

Patient name: _________________________________________

HIC #: ______________________________________

Cost information (to be completed by the supplier):

Supplier's charge _________________

Medicare fee schedule allowance_________________

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

Indicate which of the following conditions describe the patient. Circle all that apply:

1) Completely immobile—i.e. patient cannot make changes in body position without assistance.

2) Limited mobility—i.e. patient cannot independently make changes in body position significant enough to alleviate pressure.

3) Any pressure ulcer on the trunk or pelvis.

4) Impaired nutritional status.

5) Fecal or urinary incontinence.

6) Altered sensory perception.

7) Compromised circulatory status.

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

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

Physician name (printed or typed): ______________________________________

Physician signature: ______________________________________

Physician UPIN: ______________________________________

Date signed: ______________________________________