FAX: 1.844.317.9377

EMAIL: dmeorders@chcsolutions.com

SUPPORT SURFACES GROUP 2 ORDER FORM

Please attach face sheet w/ patient demographics & insurance info

PATIENT INFORMATION

Patient Name: ______________________ DOB: ____/____/______ Gender: ☐ Male ☐ Female

Language Pref.: ☐ English ☐ Spanish ☐ Other: __________

Patient cannot accept deliveries on the following days: Mon Tues Wed Thurs Fri Sat

Emergency Contact Name/Phone Number: ______________________

DIAGNOSIS

Primary Diagnosis	**Secondary Diagnosis**
ICD-10 Code: ______________	**ICD-10 Code:** ______________
*Non-Specified Codes will not qualify for Primary Diagnosis	

PRODUCTS

☐ AP Low Air Loss Mattress

☐ Assure AL Low Air Loss Mattress

☐ Low Air Loss Filter

Indicate which of the following conditions describe the patient.

Question	Answer
Does the patient have multiple stage II pressure ulcers on trunk or pelvis?	☐ Yes ☐ No
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 non-powered pressure reducing overlay mattress?	☐ Yes ☐ No
Over the past month, the patient's ulcer(s) has/have:	☐ Improved ☐ Worsened ☐ Same
Does the patient have large or multiple stage III or IV pressure ulcers on the trunk or pelvis? *Please note that if the patient is not currently receiving wound care supplies from CHC Solutions, current wound detail and history is needed.*	☐ Yes ☐ No
Has the patient had a recent (past 60 days) myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis? **If yes, please list date of surgery:** __________	☐ Yes ☐ No
Was the patient on an alternating pressure or low air loss mattress or bed or an air fluidized bed immediately prior to recent (past 30 days) discharge from hospital or nursing facility?	☐ Yes ☐ No
Does the patient currently have a hospital bed? *(A hospital bed is required for the use of this product)*	☐ Yes ☐ No

Height: __________ **Weight:** __________

Hip-to-Hip Measurement: __________

Order Date: ____/____/____

Length of Need: ________ **months**

REFERRAL INFORMATION

Ref #: __________

Practice Name: ______________________ Fax: ______________________

Office Address: ______________________ Email: ______________________

Phone: ______________________ Preferred Method of Contact? ☐ Phone ☐ Fax ☐ Email

Contact Person: ______________________

Physician Name: ______________ NPI#: __________ Phone: (____)____-______ Ext. ____

Physician Signature: ______________ Date: ____/____/______

I certify that the above products are medically necessary and that the information provided is accurate to the best of my knowledge. By signing, I acknowledge that I have obtained the patient's authorization to release the above information and other medical information that may be disclosed. I certify that my decision to prescribe this recommended product was solely based on my determination of medical necessity set forth herein. This document may serve as a confirmation of a verbal order and is also recorded in the patient's record.

Call **1.800.220.5262** or visit **www.chcsolutions.com** for additional information.

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