

**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 NPI: \_\_\_\_\_