SUPPORT SURFACE, HOSPITAL BED & WHEELCHAIR REFERRAL FORM

For use in NV

Patient Name: **Date of Birth:** **RX Date:**

Diagnosis:

- ☐ COPD (J44.9)
- ☐ Chronic Bronchitis (J42)
- ☐ Acute Bronchiolitis (J20.9)
- ☐ CHF (I50.9)
- ☐ Extrinsic Asthma (J45.20)
- ☐ Chronic Obstructive Asthma (J44.9)
- ☐ Emphysema (J43.9)
- ☐ OSA (G47.33)
- ☐ Other :_____

* *Support surfaces require a pressure ulcer diagnoses & stage (I–IV) of ulcer*

- ☐ Pressure Ulcer: _____
  Stage of Ulcer: _____

Length of Need:_____(If lifetime, use 99) Height_____ Weight:_____

Wheelchairs

- ☐ Standard Wheelchair
- ☐ Extra Heavy Duty Wheelchair
- ☐ Swing Away Leg Rests
- ☐ Lightweight Wheelchair
- ☐ Transport Chair
- ☐ Elevating Leg Rests
- ☐ Heavy Duty Wheelchair
- ☐ Fully Reclining Wheelchair

☐ Other Wheelchair Accessory_____ _____ _____

- ☐ Basic Wheelchair Cushion
- ☐ Low Pressure Wheelchair Cushion

Hospital Beds

- ☐ Semi Electric Hospital Bed
- ☐ Fixed Height Hospital Bed
- ☐ Bariatric Hospital Bed

Group I Mattress/Overlay

- ☐ Alternating Pressure Pad E0181
- ☐ Gel Mattress Pad Overlay E0185
- ☐ Egg Crate Mattress

Group II Mattress/Overlay

- ☐ Low Air Loss Mattress E0277
- ☐ Other _____

Comments/Other Orders:

Please provide face-to-face chart notes that support medical necessity with the order

I hereby certify that the services are medically necessary and are authorized by me. The patient is under my care and is in need of the services listed.

Physician's Printed Name: NPI: Fax:

Physician's Signature: Signature Date:

Medicare requires the Signature and Signature Date be completed by a PECOS enrolled MD, DO, PA, NP, or CNS