Please Fax Orders to:
317-516-0166

DEFY Therapeutics

GROUP 2 MATTRESS(LOW AIR LOSS) ORDER FORM

Patient Name: _____ DOB: _____ HT: _____ WT: _____

Address _____ City: _____ ST: _____ ZIP: _____

Ordering Physician: _____ NPI#: _____ Order Date:_____

PRESCRIBED TREATMENT OPTIONS

1. Surface: ☐ Low Air Loss Mattress (E0277) ☐ Group 2 Foam Mattress (E0373) ☐ Roho Sofflex (E0371)

2. Bed Frame Selection: ☐ Semi-Electric Hospital Bed ☐ Manual Hospital Bed (head elevation not necessary)

3. Other Needs: ☐ Skin protective wheelchair cushion (Roho) ☐ Hydraulic Lift ☐ Trapeze Bar

4. ICD-10 Diagnosis Code: L89._____ _____ _____ _____ Estimate Length of Need: _____ (99=Life)

GROUP 2 QUESTIONNAIRE

Y N 1. The beneficiary has multiple stage II pressure ulcers, or a large Stage III or IV located on the trunk or pelvis that has **not improved** over the past month

Y N 2. During this time, the beneficiary has been on a **comprehensive ulcer treatment program** that includes, *CHECK ALL THAT APPLY:*

- ☐ a) Properly using a Group 1 support surface, and
- ☐ b) Regular assessment by a nurse, physician, or other licensed health care practitioner, and
- ☐ c) Proper turning and positioning, and
- ☐ d) Proper wound care, and
- ☐ e) Proper management of moisture and or incontinence, and
- ☐ f) Nutritional assessment and intervention consistent with the overall plan of care

Y N 3. The beneficiary has Large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis as described by the diagnosis codes listed above

Y N 4. The beneficiary had a Myocutaneous Flap or Skin Graft for a pressure ulcer on the trunk or pelvis within the past 60 days as described by the diagnosis codes listed in the table given in the relevant LCD(s), and has been on a Group 2 or 3 support surface given at once before discharge from a hospital or nursing facility within the past 30 days

PHYSICIAN ATTESTATION

By signing below, I certify that the information is accurate as supported by accompanying chart notes and this item is medically necessary

Physician's Signature (no stamps) Order Date