Phone: 586-778-2500
Fax: 866-565-5190

Equipment Request Form

Group I Support Surfaces
(Alternating Pressure Pads, Gel Overlays)

Per Medicare requirements, a **SIGNED PHYSICIAN'S ORDER is required PRIOR TO delivery**. Please answer all questions below and return to Renaissance Medical. In addition, please make sure a signed copy is kept in your patient's file.

Patient Full Name: _____ Date of Birth: _____

Address City/St/Zip: _____

Medicare # _____ Other Ins Type & # _____

Referring Facility/Name: _____ Contact Name: _____

Requested Delivery Date: _____ Approx Time: _____

A Group I Support Mattress or Overlay (E0180-E0189, E0196-E0199, A4640) is covered if the patient meets:

a) Criterion 1 OR

b) Criterion 2 OR Criterion 3, AND at least ONE of criteria 4-7.

PLEASE MARK 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 stage pressure ulcer** on the **trunk or pelvis.**

4) ☐ **Impaired nutritional status.**

5) ☐ **Fecal or urinary incontinence.**

6) ☐ **Altered sensory perception**.

7) ☐ **Compromised circulatory status.**

Height: _____ Weight: _____ Length of Need (Months) (99=Lifetime): _____

Diagnosis(es) that qualify the need of item delivered: _____

Ordering Physician, PA, or Nurse Practitioner Name (Please Print): _____

Ordering Physician, PA, or Nurse Practitioner Signature: _____ Date: _____/_____/_____

NPI: _____

Please Fax This Page with Patient Demographics To: 1▪866▪565▪5190