

ArmsCare Inc.

Hospital Equipment and Services in Your Home
1-888-545-4949 or 724-545-3200

Wound Care Support Surfaces

Fax to: 724-543-2718

Referral Information:

Date _____ Time _____
Facility _____ Facility Contact Person: _____
Facility Address: _____
_____ RM#: _____
Phone# _____ Fax# _____

Patient Information:

Patient Name _____ SSN#: _____
Diagnosis _____ D.O.B. _____ Phone: _____
Address _____

Emergency Contact _____ Emergency Phone _____
Special Instructions/Education _____

Insurance Information:

Primary Insurance _____
ID# _____ Group # _____
Secondary Insurance _____
ID# _____ Group # _____

Services/Problems/Needs	
Physician Name: _____ Phone: _____	
Address: _____ Fax: _____	
Physician NPI # _____	

Serving Armstrong and the surrounding Counties

Statement of Ordering Physician

Group 1 Support Surfaces

Patient Name: _____

HIC #: _____

E0181 Powered Pressure reducing mattress overlay/pad, alternating, with pump, includes heavy duty (app)

Patient Diagnosis: _____

ICD-9 Codes that support Medical Necessity: _____

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): _____

Address: _____

Phone: _____ Fax: _____

Physician Signature: _____

Physician NPI: _____ Date: _____