

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 2 Support Surfaces

Patient Name: _____

HIC #: _____

E0277 Powered Pressure Reducing Mattress

ICD-9 Codes that support Medical Necessity, Circle all that apply:

707.02	Decubitus ulcer upper back – shoulder blades
707.03	Decubitus ulcer lower back – sacrum
707.04	Decubitus ulcer hip
707.05	Decubitus ulcer buttocks

Circle **Y** for yes, **N** for No, **D** for Does not apply, unless otherwise noted.

Y N D 1) Does the patient have multiple stage II pressure ulcers on the trunk or pelvis?

Y N D 2) Has the patient been on a comprehensive ulcer treatment program for at least the past month which has included the use of an alternating pressure or low air loss overlay which is less than 3.5 inches, or a no powered pressure reducing overlay or mattress?

1 2 3 3) Over the past month, the patient's ulcer (s) has/have:
1) Improved 2) Remained the same 3) Worsened?

Y N D 4) Does the patient have large or multiple stage III or IV pressure ulcer (s) on the trunk or pelvis?

Y N D 5) Has the patient had a recent (within the past 60 days) myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis? If yes, give date of surgery:

Y N D 6) Was the patient on an alternating pressure or low air loss mattress or bed or an air fluidized bed immediately prior to a recent (within the past 30 days) discharged from a hospital or nursing facility?

Estimated length of need (# of months): _____ 99 = lifetime: _____

Physician name (printed or typed): _____

Address: _____

Phone: _____ Fax: _____

Physician Signature: _____

Physician NPI: _____ Date: _____