PHONE: 1.800.344.1550 FAX: 1.844.317.9377
EMAIL: orders@chcsolutions.com

GROUP 2 SUPPORT SURFACES ORDER FORM

Please attach face sheet w/ patient demographics & insurance info

PATIENT INFORMATION

Patient Name: ______________________________ DOB: ______/______/_________ Gender: ☐ Male ☐ Female

Language Pref.: ☐ English ☐ Spanish ☐ Other: __________________

Patient cannot accept deliveries on the following days?
Mon Tues Wed Thurs Fri Sat

DIAGNOSIS

Primary Diagnosis
ICD-10 Code: ______________________________
*Non-Specified Codes will not qualify for Primary Diagnosis

Secondary Diagnosis
ICD-10 Code: ______________________________

Indicate which of the following conditions describe the patient.

Does the Patient have multiple stage ll pressure Ulcers on trunk or pelvis?	☐ Yes ☐ No
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 non-powered pressure reducing overlay mattress?	☐ Yes ☐ No
Over the past month, the patient's ulcer(s) has/have:	☐ Improved ☐ Worsened ☐ Same
Does the patient have large or multiple State lll or lV pressure ulcers on the trunk or pelvis?	☐ Yes ☐ No
Has the patient had a recent (past 60 days) myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis? **If yes, please list date of surgery:**______________________	☐ Yes ☐ No
Was the patient on an alternating pressure or low air loss mattress or bed or an air fluidized bed immediately prior to recent (past 30 days) discharge from hospital or nursing facility?	☐ Yes ☐ No

Order Date: _____/______/______

Length of Need: __________ **months**

REFERRAL INFORMATION

Ref #: ____________________

Practice Name: ______________________________

Office Address: ______________________________

Phone: ______________________________

Contact Person: ______________________________

Fax: ______________________________

Email: ______________________________

Preferred Method of Contact? ☐ Phone ☐ Fax ☐ Email

Physician Name: ______________________ NPI#: ________________ Phone: (_______)_______-__________ Ext. _______

Physician Signature: ______________________________ Date: ______/______/_________

I certify that the above products are medically necessary and that the information provided is accurate to the best of my knowledge. By signing below, I acknowledge that I have obtained the patient's authorization to release the above information and other medical information that may be disclosed. I certify that my decision to prescribe this recommended product was solely based on my determination of medical necessity set forth herein. This document may serve as a confirmation of a verbal order and is also recorded in the patient's record.

Assignment of Benefits: *I request that payment of my insurance benefits be made to CHC Solutions, Inc., or any of its subsidiaries, for any supplies or services they provide me. I am responsible for any balance due that is not covered by my insurance. I understand any product received in my home cannot be returned if opened. By signing below, I authorize the distribution of my information to CHC Solutions, Inc., or any of its subsidiaries, which may be needed to determine benefits payable for these services or supplies. I authorize CHC Solutions,,,,, Inc., or any of its subsidiaries, to forward my medical records to the medical professionals in my care and/or make copies of said records.*

Patient Signature: ______________________________ Date: ______/______/_________

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