Statement of Ordering Physician
Group 1 Support Surfaces

www.AtlanticHP.com/Rx

Patient name: ____

NBI #: ____

Cost information (to be completed by the supplier):

Supplier's charge ________________________________

Medicare fee schedule allowance____________________

The information below may not be completed by the supplier or anyone in a financial relationship with the supplier.

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): ____

Physician signature: ____

Physician NPI: ____

Note: Fax this form and patient demographic sheet which includes insurance information to 561-290-1434.

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6782 Forest Hill Blvd, West
Palm Beach, FL 33411
561-964-6767

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