Specialty Mattress Overlay GROUP l or GROUP II:

DME Medical Review Form

Quality and Utilization Improvement Dept.	Telephone # (888) 467-0774
DME - Medical Policy	Fax # (952) 853-8714

To be completed by a Health Professional (MD, NP, etc), not Vendor or Member.
Please answer all of the following questions. This information is required in order to determine whether coverage criteria are met.

Member Name:	**Date of Birth:**	**Member #:**
Completed by:	**Phone #:**	**Fax #:**

MD ordering (*Print Name*): _______________________________ Date completed: _____________

1. Diagnosis: ____
2. Is member completely immobile (i.e. cannot move without assistance.)? ☐ Yes ☐ No
3. Does member have limited mobility (i.e., cannot independently make changes in body position significant enough to alleviate pressure)? ......☐ Yes ☐ No
4. Does member have a pressure ulcer on the trunk or pelvis? ....☐ Yes ☐ No
   For each wound indicate location, stage, and measurements____________________________
   ____
   ____
5. Does member have an impaired nutritional status?......................... ☐Yes ☐ No
6. Does member have fecal or urinary incontinence?...................... ☐ Yes ☐ No
7. Has member been on a comprehensive ulcer treatment program for at least the past month?..☐ Yes ☐No
   Did this include use of a Medicare group I support surface?..............................☐ Yes ☐ No
8. Has member had a recent myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis?...☐Yes ☐ No
   Date of surgery: ______________________________
9. Has the member been on a Medicare group II or III support surface immediately prior to a recent discharge from a hospital or nursing facility? .... ☐ Yes ☐ No
   Date of discharge: ____________________________
10. Does member have an altered sensory perception?......................... ☐Yes ☐No
11. Does member have a compromised circulatory status?.....................☐ Yes ☐ No
12. Have the ulcers worsened or remained the same over the past month?.....☐ Yes ☐ No

Additional information:____
____

Physician or Treating Practitioner Signature: Date:

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