Specialty Mattress Overlay GROUP 1 or GROUP II:

DME Medical Review Form

Quality and Utilization Improvement Dept. Telephone # (952) 883-5741
DME - Medical Policy Fax # (952) 853-8714

*Please answer ALL of the following questions. This information is ***REQUIRED*** in order to determine if member meets coverage criteria.*

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

MD ordering (*Print Name*): ______________________________ Date Completed: ____________

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

Additional information:____
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