HealthPartners

Specialty Mattress Group III (Air Fluidized Bed)

DME Medical Review Form

To be completed by a Health Professional (MD, NP, etc.), not Vendor

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

Ordering practitioner:	NPI #:
Clinic name:	Clinic NPI# or Fed Tax ID#
Clinic phone #:	Clinic fax #:
Diagnosis:	ICD-9/10:

Attach completed Braden Scale if available

1. Does member have a stage III or Stage IV pressure ulcer? ☐ Yes ☐ No
   For each wound, indicate location, stage and measurements: _____
   _____
2. Is member bedridden or chair bound? ☐ Yes ☐ No
3. Would this member require institutionalization without an air fluidized bed? ☐ Yes ☐ No
   If yes, please explain: _____
   _____
4. Has member failed conservative treatment? ☐ Yes ☐ No
   Indicate treatments attempted and failed: _____
   _____
5. Is a trained adult caregiver available to assist the member with all care required? ☐ Yes ☐ No
6. What other equipment has been considered and ruled out? _____
   _____

Additional information: _____
_____
_____
_____

I confirm that the information above is correct.
Physician or Treating Practitioner Signature: **Date:**

Please fax this completed form to member's Durable Medical Equipment Vendor.
For questions, call (952) 883-6333

Please include fax cover sheet when submitting