HealthPartners

Specialty Mattress Overlay Group I or Group II

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:

1. Is member completely immobile (i.e. cannot move without assistance)? ☐Yes ☐No
2. Does member have limited mobility (i.e., cannot independently make changes in body position significant enough to alleviate pressure)? ☐Yes ☐No
3. Does member have a pressure ulcer on the trunk or pelvis? ☐Yes ☐No
   For each wound indicate location, stage, and measurements: ______________________________
   ____
   ____
4. Does member have impaired nutritional status? ☐Yes ☐No
5. Does member have fecal or urinary incontinence? ☐Yes ☐No
6. Has member been on a comprehensive ulcer treatment program for at least the past month? ☐Yes ☐No
7. 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 altered sensory perception? ☐Yes ☐No
11. Does member have compromised circulatory status? ☐Yes ☐No
12. Have the ulcers worsened or remained the same over the past month? ☐Yes ☐No

Additional information

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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.