HANDI MEDICAL SUPPLY

Standard Written Order: Group II Support Surface

Prescriber Information

Clinic/Location Name:
Prescriber Name:
Prescriber Address:
Prescriber City State Zip:
Prescriber Phone:
Prescriber Fax:
Prescriber NPI:

Patient Information

Patient Name:
Patient Address:
Patient City State Zip:
Phone:
DOB:
Primary Insurance:
Handi Customer Number:
Homecare Agency:

Diagnosis (ICD-10) *select all that apply*

Select or write in Diagnosis Code (ICD-10)
Select or write in Diagnosis Code (ICD-10)
Select or write in Diagnosis Code (ICD-10)

HCPC	Description	Dispensing Qty
☐ E0277	POWERED PRESSURE-REDUCING AIR MATTRESS	1 each every 5 years
☐ E0373	NONPOWERED ADVANCED PRESSURE REDUCING MATTRESS	1 each every 5 years

1. Ordered Date: _____ **2. Length of Need:** _____

Leaving blank presumes Lifetime (99 months)

3. Please attach medical records, including wound measurements, supporting the necessity of the above ordered item(s).

4. Additional comments or Diagnosis Codes not listed above:

5. _____ _____
Physician/NP/PA/Medical Practitioner Signature — Date

: Signer must match Prescriber Information at the top of this form, or be updated below

Print New Prescriber Name: _____ NPI: _____

  Tel: 651-644-9770 or 800-514-9979 2505 University Avenue West, St. Paul, MN 55114