JONES MEDICAL EQUIPMENT
481-B Elma G. Miles Parkway Hinesville, GA 31313 Phone 912-877-3202 Fax 912-877-3206
NPI 1578900841
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*****ALL PHYSICIANS SCRIPTING FOR MEDICARE AND MEDICAID MUST BE PECOS CERTIFIED AND ENROLLED WITH GAMMIS. INFORMATION WILL BE VERIFIED DURING THE INTAKE PROCESS AND DENIED, IF YOU'RE NOT ENROLLED*****

Support Surface- Monthly Wound Evaluation Required

Patient Name _____ DOB _____

Insurance _____ MBI # _____

Order Date _____ End Date _____

Treating Provider _____ NPI _____

Phone # _____ Fax # _____

Equipment Ordered (Circle/Check All that Apply)

List Base Equipment: _____ Purchased Date: _____

E2601 General Wheelchair seat cushion <22 in.
E2602 General Wheelchair seat cushion, >=22 in.
E0185 Gel Overlay, prevention Mattress
E0277 Power Pressure Reducing Air Mattress
E0181 Alternating Pressure Pad and Pump
E0193 Low Air Loss Mattress
E0194 Air Fluidized Bed
Other _____

To be completed (must be signed by the ordering M.D.)

Prognosis (circle) Fair Good Poor Length of Need _____ (99= lifetime)

Date of Order (RX) _____ Date of Office Visit _____

DX _____ ICD-10 Code _____

Please answer below (this documentation must also be documented in your progress notes for this patient:

1. Is the patient completely immobile? Yes or No
2. Does the patient have one or more pressure ulcers on the trunk or pelvis? Yes or No
3. Does the patient have one or more of the following conditions? (check all that apply)
   a. Impaired nutritional status
   b. Fecal/Urinary Incontinence
   c. Altered sensory perception
   d. Compromised circulatory status
4. Is there documentation of a plan of care by the provider or home health nurse?
   If yes, who? _____
5. Will the physician direct the home care regimen and re-evaluate and recertify the need on a monthly basis?
   Yes No If not, who is the home health agency? _____
6. What alternative has been tried and failed for this patient? _____
7. Would this patient be institutionalized in the absence of this equipment? Yes or No
8. Is there a caregiver available to assist with this patients care? Yes or No

_____ _____
PROVIDER SIGNATURE DATE