Diamond Medical Equipment
1324 N. Ferrell Court # 102
Gilbert, AZ 85233

Statement of Ordering Physician

Group 1 Support Surfaces

Patient Name: _____

HIC#: _____

Cost information (to be completed by the supplier):

Supplier's charge: _____

Medicare fee schedule allowance: _____

The information below may not be completed by the supplier.

Indicate which of the following conditions describe the patient. Circle all that apply.

1. Completely immobile patient cannot make change in body position without assistance.
2. Limited mobility patient cannot independently make changes in body position significant enough to alleviate pressure.
3. Any pressure ulcer on the trunk or pelvis.
4. Impaired nutritional status.
5. Fecal or urinary incontinence.
6. Altered sensory perception.
7. Compromised circulatory status.

Estimated length of need (# of months): _____ (99 = lifetime)

If none of the above applies, attach a separate sheet documenting medical necessity for the item ordered.

Physician Name (printed or signed): _____

Physician Signature: _____

Physician's UPIN #: _____

Date Signed: _____