BLACKBURN'S
HAR-KEL INC. Medical Specialties a division of BLACKBURN'S

Group 2 (Power Pressure-Reducing Air Mattress L33642-E0277) Certification Form

Phone: 800-472-2440 Fax: 724-230-3705

Please complete all the information below and attach all patient demographic information

Please contact Customer Service with any questions

PATIENT

First Name: _____ Last Name: _____ Male: ☐ Female: ☐

Address: _____ DOB: _____ HGT: _____ WGT: _____

City: _____ State: ___ Zip: _____ Phone: _____ Alternate Phone: _____

Email: _____ Patient's Preferred Language: ☐ English ☐ Spanish Other: _____

Responsible / Emergency Contact: _____ Phone: _____

Is the patient being seen by a Home Health Agency? ☐ Yes ☐ No Has the patient been notified of this order? ☐ Yes ☐ No

INS

Primary Insurance: _____ Policy ID # _____ Group #_____ Phone: _____

Secondary Insurance: _____ Policy ID # _____ Group #_____ Phone: _____

Section I: WOUND ASSESSMENT (Please attach chart notes that include detailed wound information)

Wound	Type	Location	Stage	Length X Width	Depth	Tunnelling	Drainage Amount / Color	Wound Color	Odor (Yes / No)
1.	_____	_____	_____	_____cm X _____cm	_____cm	_____ cm	_____ / _____	_____	_____
2.	_____	_____	_____	_____cm X _____cm	_____ cm	_____ cm	_____ / _____	_____	_____

Section II: CERTIFICATION INFORMATION (Please attach chart notes that include detailed information)

At least one of the following three Criteria (1,2, or 3) MUST be met, check at least one.

1. ☐ The patient has **multiple** stage 2 pressure injuries (PI) located **on the trunk and/or pelvis** which have failed to improve over the past month, during which time the patient has been on a comprehensive PI treatment program **including each** of the following:

a. Use of an appropriate Group 1 Pressure Reducing Support Surface (PRSS), **and**
b. Regular assessment by a clinician, **and**
c. Appropriate turning and positioning, **and**
d. Appropriate wound care, **and**
e. Appropriate management of moisture and incontinence, **and**
f. Nutritional assessments and interventions consistent with the Plan of Care.

OR

2. ☐ The patient has large or multiple stage 3 and/or 4 PIs **on the trunk and/or pelvis.**

OR

3. ☐ The patient **had** a myocutaneous flap or skin graft for a pressure injury **on the trunk and/or pelvis** within the past 60 days, **and** the patient has been on a Group 2 or Group 3 PRSS immediately prior to discharge from a hospital or nursing facility within the past 30 days.
(Coverage is limited to 60 days post surgery!)

Section III: TREATMENT INFORMATION (Please attach chart notes that include detailed treatment information)

All the following Criteria MUST be met, ALL must be checked.

I.	☐ A Plan of Care is established which includes the elements in Section II, # 1 above.
II.	☐ Nutritional assessments and interventions are consistent with the Plan of Care.
III.	☐ Continued use of the PRSS is medically necessary for wound management and is in the Plan of Care.
IV.	☐ The PRSS provided is one in which the patient does not "bottom out".
V.	☐ A turning and repositioning schedule is in place, is being followed, and is in the Plan of Care.
VI.	☐ The patient is assessed, at least weekly, by a clinician.
VII.	The patient has been provided a hospital type bed appropriate for the PRSS. ☐ YES ☐ NO **If NO, one will be provided with the PRSS.**

Section III: CLINICIAN / REFERRAL INFORMATION

Facility / Office Name: _____ Phone: _____

Address: _____ Fax: _____

Name of Clinician completing monthly wound tracking records (attached): _____

Email: _____

How would you prefer to be contacted: ☐ Phone ☐ Fax ☐ Email

BY SIGNING BELOW, I CERTIFY that I am the clinician identi ied in this section and AUTHORIZE *the use of this document as an order. I certify that the above prescribed supplies are medically necessary and reasonable. I will maintain an orginal signed and dated copy of this order in my medical records.*

Ordering Clinician or Licensed Presciber: (Please Print - Stamps not permitted) _____

Signature: _____ Date: _____ MD# _____ NPI: _____

LENGTH NEEDED: ☐ 3 Months ☐ Other: _____

Complete & attach ALL current supporting documentation. Fax to **724-230-3705 OR** email to: **ralph.phillips@blackburnsmed.com**