Gel cushion L15887

ALLSTATE DME LLC
4949 N. McColl Rd.
McAllen, TX 78504

Phone (956) 992-8866
FAX (956) 287-8586

Provider No. 6385310001

PATIENT: ____________________________________

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Phone ____________________________________

DOB ____________________________________

Policy: ____________________________________

Initial Date ____________________________________

Revised Date ____________________________________

Recertification

Length of Need : ____________________________________

PHYSICIAN: ____________________________________

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UPIN ______________ **NPI** ______________________

Phone ____________________________________

DIAGNOSIS

ICD-9 Code	Description
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____________	____
____________	____
____________	____

EQUIPMENT/SERVICES

Qty	Proc. Code	Item Name/Narrative
1	E2607	GEL CUSHION/MEMORY FOAM

ADDITIONAL MEDICAL INFORMATION (circle one please)

1. Does the patient have a manual wheelchair or a power wheelchair with a sling/solid seat/back and the patient meets Medicare coverage criteria for it? ☐ Y ☐ N

2. Does the patient have either of the following:

3. Current pressure ulcer (ICD-9-CM codes 707.03, 707.04, 707.05) or past history of a pressure ulcer (707.03, 707.04, 707.05) on the area of contact with the seating surface? ☐ Y ☐ N

4. Does the patient have absent or impaired sensation in the area of contact with the seating surface or inability to carry out a functional weight shift due to one of the following diagnoses: spinal cord injury resulting in quadriplegia or paraplegia (344.00-344.) ? ☐ Y ☐ N

Dear Physician,
The following information was provided to our office as part of the order intake process. Please confirm that the information is correct. If the information is correct it needs to be inserted into the attached Written Order form. Any changes or corrections should also be inserted into the attached form. Once all sections of the Written Order are completed, please sign, date and mail the form back to our office. Thank you.

Clinician Signature ______________________ **Date** __________________