Specialty Mattress GROUP III: (Air Fluidized Bed)
DME Medical Review Form

Quality and Utilization Improvement Dept.	Telephone # (888)467-0774
DME - Medical Policy	Fax # (952) 853-8714

To be completed by a Health Professional (MD, NP, etc), not Vendor or Member.

*****Please answer ALL of the following questions. This information is **required** in order to determine whether coverage criteria are met.*****

Member Name:	**Date of Birth:**	**Member #:**
Completed by:	**Phone #:**	**Fax #:**

MD ordering (Print First & Last Name): _____

Date Completed: _____

Attach completed Braden Scale if available

1. Diagnosis _____
2. Does member have a stage III or Stage IV pressure ulcer? .....☐Yes ☐ No
   For each wound, indicate location, stage and measurements_____
   _____
3. Is member bedridden or chair bound? .....☐Yes ☐No
4. Would this member require institutionalization without an air fluidized bed?...☐Yes ☐ No
   If yes, please explain _____
5. Has member failed conservative treatment?.....☐Yes ☐ No
   Indicate treatments attempted and failed _____
   _____
6. Is a trained adult caregiver available to assist the member with all care required? ☐Yes ☐No
7. What other equipment has been considered and ruled out _____
   _____

Additional information:

_____
_____
_____

Physician or Treating Practitioner Signature: **Date:**

CoOportunity Health has contracted with HealthPartners Administrators, Inc. to provide claims processing, medical management and certain other administrative services.