

**ABSOLUTE
MEDICAL
EQUIPMENT, INC.**

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Fayetteville, Ga. 30214
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Wheelchair Pressure Relief Gel Cushion

Date: _____

Patient Name: _____

Address: _____

Phone: _____ Date of Birth: _____

PROGNOSIS: _____ LENGTH OF NEED: _____



IN ORDER FOR THIS CUSHION TO BE MEDICALLY NECESSARY UNDER MEDICARE GUIDELINES, THE PATIENT MUST HAVE ONE OF THE FOLLOWING DIAGNOSIS DOCUMENTED. **PLEASE SELECT ALL THAT APPLY:**

Current pressure ulcer (707.03, 707.04, 707.05) ****please circle to specify area****

Past history of a pressure ulcer (707.03, 707.04, 707.05) on the area of contact with the seating surface ****please circle to specify area****

or

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 diagnosis:

- 344.00-344.1 - spinal cord injury resulting in quadriplegia or paraplegia
- 336.0-336.3 - other spinal cord disease
- 340 - multiple sclerosis
- 341.0-341.9 - other demyelinating disease
- 343.0-343.9 - cerebral palsy
- 335.0-335.21, 335.23-335.9 - anterior horn cell diseases including amyotrophic lateral sclerosis
- 138 - post polio paralysis
- 344.09 - traumatic brain injury resulting in quadriplegia
- 741.00-741.93 - spina bifida
- 330.0-330.9 - childhood cerebral degeneration
- 331.0 - Alzheimer's disease
- 332.0 - Parkinson's disease

**Please specify exact
Diagnosis Code:**

Physician Name: _____

Address: _____

Phone: _____ NPI#: _____

X _____

DATE _____

Physician Signature