416 Shiloh Drive, Ste. C-3
Laredo, TX 78045
Phone (956) 753-2211
NPI 1720028442

Med Mart
Standard Written Order
Fax to: (956) 753-2266
Email to: laredo@shopmedmart.com

STANDARD WRITTEN ORDER

Date: _____

PATIENT INFORMATION

NAME	PHONE	DOB	SEX	HT/WT

STREET	CITY	STATE	ZIP

PRIMARY INS	POLICY #	DX CODE(S)

SECONDARY INS	POLICY #	Email

Note: Specific criteria must be met to determine insurance coverage for prescribed items

Wheelchairs

- ❒ Standard (K0001)
- ❒ Lightweight (K0003)
- ❒ Nonstd seat frame: seat with ≥ 20", < 24" (E2201)
- ❒ Heavy Duty - Pt Wt ≥ 250 lbs. (K0006)
- ❒ Ex. Heavy Duty - Pt Wt ≥ 300 lbs. (K0007)
- ❒ Transport Chair (E1038)
- ❒ Elevated Leg Rests (K0195)
- ❒ Other _____

Wheelchair Cushions

- ❒ General Seat Cushion <22" (E2601)
- ❒ General Seat Cushion >22" (E2602)
- ❒ Gel Seat Cushion >22" (E2604)
- ❒ Gel Seat Cushion <22" (E2603)
- ❒ Back Cushion <22" (E2611)
- ❒ Back Cushion >22" (E2612)

Ambulatory Aids

- ❒ Cane, Single Point (E0100)
- ❒ Cane, Quad (E0105)
- ❒ Walker, 2 – Wheeled (E0143)
- ❒ Walker, Wheeled Heavy Duty Pt Wt ≥ 300 lbs (E0149)
- ❒ Walker, Rollator w/Seat Attach (E0143 & E0156)
- ❒ Commode, Three in One (E0163)
- ❒ Shower Chair w/wheels (Title XIX only)

Hospital Beds & Accessories

- ❒ Semi Electric Hospital Bed (E0260)
- ❒ Gel Overlay (E0185)
- ❒ Heavy Duty Hospital Bed (E0303) weight > 350 pounds < 600 pounds
- ❒ Other _____

Enteral Nutrition

Please circle prescribed formula and choose mode of administration

- ❒ B4150 Boost, Ensure, Fibersource HN, Isosource HN, Jevity 1.0, Jevity 1.2, Nutren 1.0, Nutren 1.0 Fiber, Nutren Replete, Nutren Replete Fiber, Osmolite 1.0, Osmotlite 1.2, Promote, Promote Fiber
- ❒ B4152 Boost Plus, Ensure Plus, Isosource 1.5, Jevity 1.5, Nutren 2.0, Nutren 1.5, Osmolite 1.5, TwoCal HN
- ❒ B4153 Peptamen, Peptamen 1.5, Peptamen AF
- ❒ B4154 Diabetasource AC. Glucerna 1.0, Glucerna 1.2, Glucerna 1.5, Nepro
- ❒ Enteral Pump (B9002) Rate _____mL Duration _____ IV Pole (E0776) Feeding Bags (B4035) 30 Day Supply
- ❒ Bolus Syringes (B4034) 30 Day Supply _____mL/cans QD (circle one)

Nebulizer

- ❒ Nebulizer, with Compressor (E0570)
- ❒ Nebulizer Administration Set (A7003)
- ❒ Aerosol Mask (A7015)

Inhalation Drug to be used with Nebulizer **(drug will NOT be supplied by DME)** _____

Include with Referral Form:

- ❒ Recent progress notes
- ❒ Documentation of medical necessity form

Length of Need for Prescribed _____

_____ Physician's Name (Print)

_____ NPI

_____ Physician's Signature

_____ Date

Thank you for your business!

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Medical Necessity Documentation

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Name _____ DOB _____ Medicare/ Insured # _____

Ambulatory Aids

❒	Cane (E0100, E0105)	Patient has a mobility limitation that significantly impairs their ability to participate in one or more MRADL in the home.
❒	Walker (E0135, E0143)	Patient has a mobility limitation that significantly impairs their ability to participate in one or more MRADL in the home; AND prevents the patient from accomplishing MRADL entirely; **OR** patient is at heightened risk of morbidity or mortality secondary to the attempts to perform MRADL; **OR** prevents the patient from completing MRADL w/in a reasonable time frame.
❒	Walker, Heavy Duty (E0149)	Meets E0143 criteria **AND** weighs more than 300 pounds.

Standard Wheelchair (K0001)

❒ 1. Patient has mobility limitation; **AND** will use to complete toileting, feeding, dressing, grooming, and bathing; **AND**
❒ 2. Patient willing to use wheelchair in the home; **AND** mobility cannot be sufficiently resolved using an appropriately fitted cane or walker; **AND**
❒ 3. Patient has a caregiver who is available, willing, and able to assist with the wheelchair; **AND**
❒ 4. Patient fatigues easily; **AND** has low endurance; **AND** is non weight bearing, partial weight baring or weight bearing as tolerated; **AND**
❒ 5. Patient has sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the manual wheelchair in the home; **OR** has a caregiver who is available, willing, and able to assist with the wheelchair.

Lightweight Wheelchair (K0003)

❒ Patient meets criteria 1-5 for K0001; **AND**
❒ Patient cannot self-propel in a standard wheelchair in the home; AND
❒ Can and does self-propel in a lightweight wheelchair

Heavy-Duty Wheelchair (K0006)

❒ Patient meets criteria 1-5 for K0001; **AND**
❒ Weighs more than 250 pounds **OR**
❒ Has severe spasticity

Extra Heavy-Duty Wheelchair (K0007)

❒ Patient meets criteria 1-5 for K0001; **AND**
❒ Patient weighs more than 300 pounds

W/C Seat & Back Cushions (E2601, E2602, E2611, E2612)

❒ Patient will have prolong sitting in wheelchair
❒ Patient is at risk for skin breakdown

WC Accessories

❒ Reclining Back (E1226) High risk for pressure ulcers
❒ Elevated Leg Rests (K0195) LE cast, edema, or has reclining back

Nebulizer (E0570, A7003, A7015)

❒ Medical record supports that it is medically necessary to administer a FDA-approved inhalation solution. Medical record should contain the name of the drug to be used with nebulizer and the condition.

Hospital Bed (E0260, E0303)

❒ The patient has a medical condition which requires positioning of the body in ways not feasible with an ordinary bed; OR
❒ The patient requires positioning of the body in ways not feasible with an ordinary bed to alleviate pain; OR
❒ The patient requires the head of the bed to be elevated more than 30 degrees most of the time due to CHF, COPD, or problems with aspiration, OR
❒ The beneficiary requires frequent changes in body position and/or has an immediate need for a change in body position.
❒ The patient's weight is more than 350 pounds but does not exceed 600 pounds.

Gel Overlay (E1085) for Hospital Bed

❒ The patient is immobile ❒ The patient has limited mobility ❒ The patient has any stage pressure ulcer

Enteral Nutrition

❒ The patient has a permanent (at least 3 months) impairment due to non-function or disease of the structures that permit food to reach the small bowel
❒ The patient has a permanent (at least 3 months) impairment of the small bowel which impairs digestion and absorption of an oral diet
❒ The nutrition is being provided via a tube into the stomach or small intestine (Oral consumption will result in denial of claim)
❒ The patient requires tube feedings to maintain weight and strength
❒ Adequate nutrition is not possible through dietary adjustment and or oral supplements

➢ **For special nutrient formulas (B4153, B4155): records must document the medical condition requiring the special nutrient formula opposed to a B4150 formula and the severity shown by history, physical exam, and diagnostic/laboratory studies. In addition, the records must document a response of the medical condition to a B4150 formula compared to the response to the special nutrient formula. If a comparison was not made, the medical reason for its absence must be supported by medical necessity other than diagnosis.**

Ordering Physician	**Signature**	**NPI**	**Date**