Order Date:_____

WRITTEN DME ORDER PRIOR TO DELIVERY

Patient Name:_____ **Patient DOB:**_____

Patient Address:_____ **SSN#**_____

City:_____ **Patient Telephone #**_____

State:_____ **Prognosis:**_____

Diagnosis:_____ **Length Of Need:**_____ **(99) Months = Lifetime** **Ht/Wt**:_____
(icd-10)

☐ **E0260** **Description: Semi Electric Bed W/Rails and Mattress Qty: 1**

Indicate if one or more of the following conditions describe the patient. (Check) all that apply.

☐ A. Patient has medical condition which requires positioning of the body in ways not feasible with an ordinary bed.
☐ B. Patient requires positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain.
☐ C. 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.
☐ D. Patient requires traction equipment, which can only be attached to a hopital bed.

AND

☐ Patient requires frequent changes in body position and/or has an immediate need for a change in body position.

☐ **E0185** **Description:Gel/Foam Overlay Mattress Qty: 1**

Indicate if one or more of the following conditions describe the patient. (Check) all that apply.

☐ A. Completely immobile - i.e. patient cannot make changes in body position without assistance.
☐ B. Limited mobility - i.e. patient cannot independently make changes in body position significant enough to alleviate pressure.
☐ C. Any pressure ulcer on trunk or pelvis.
☐ D. Impaired nutritional status.
☐ E. Fecal or urinary incontinence.
☐ F. Altered sensory perception.
☐ G. Compromised circulatory status.

☐ **E0910** **Trapeze for Hospital Bed**
☐ **E0630** **Patient lift**

☐ **E0163** **Bedside Commode**
☐ **E1035** **Patient Transfer system**

I, the undersigned, certify that the above prescribed equipment/supplies is medically necessary for part of my treatment for this patient.
In my opinion, the equipment prescribed is reasonable and necessary for accepted standards of medical practice and treatment
of this patient's condition and has not been prescribed as "conveniance equipment".

Date Patient Last Seen: _____

Physician Name:_____

Physician Address:_____ **Physician Telephone #** _____

City:_____ **State:**_____ **Zip Code:**_____ **NPI #**_____

Physician Signature:_____ **Date:**_____