



STANDARD WRITTEN ORDER

PATIENT INFORMATION		Date: _____		
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

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

Wheelchair Cushions

- | | | |
|--|--|--|
| <input type="checkbox"/> General Seat Cushion <22" (E2601) | <input type="checkbox"/> Gel Seat Cushion >22" (E2604) | <input type="checkbox"/> Back Cushion <22" (E2611) |
| <input type="checkbox"/> General Seat Cushion >22" (E2602) | <input type="checkbox"/> Gel Seat Cushion <22" (E2603) | <input type="checkbox"/> Back Cushion >22" (E2612) |

Ambulatory Aids

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

Hospital Beds & Accessories

- | | |
|---|---|
| <input type="checkbox"/> Semi Electric Hospital Bed (E0260) | <input type="checkbox"/> Heavy Duty Hospital Bed (E0303) weight > 350 pounds < 600 pounds |
| <input type="checkbox"/> Gel Overlay (E0185) | <input type="checkbox"/> 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, Osmolite 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

- | | | |
|---|---|---|
| <input type="checkbox"/> Nebulizer, with Compressor (E0570) | <input type="checkbox"/> Nebulizer Administration Set (A7003) | <input type="checkbox"/> 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!

JMS

Medical Necessity Documentation

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 bearing 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