THE MED MART CORPORATION

DME/RESPIRATORY/ENTERAL SERVICES

PH – 210-697-9933 FAX – 210-697-8753

PATIENT INFORMATION

Date: ___________________________

NAME	PHONE	SS#	DOB	SEX
STREET	CITY	STATE	ZIP	HT/WT
PRIMARY INS	POLICY #	GRP#	INSURED'S NAME	
SECONDARY INS	POLICY #	GRP#	INSURED'S NAME	
PHYSICIAN	NPI		DIAGNOSIS	
SPECIAL INSTRUCTIONS			PROGNOSIS	

WHEELCHAIRS

- ❒ STANDARD WHEELCHAIR (K0001)
- ❒ LIGHT WEIGHT WHEELCHAIR (K0003)
- ❒ HEAVY DUTY WHEELCHAIR 250 LBS+ (K0006)
- ❒ EXTRA HEAVY DUTY WHEELCHAIR 300 LBS+ (K0007)
- ❒ ELEVATED LEG RESTS (K0195)
- ❒ ANTITIPPERS
- ❒ SEAT BACK CUSHION*
- ❒ FOAM CUSHION*
- ❒ GEL CUSHION*

*NOTE: Patient must have a wheelchair and meet insurance coverage criteria for it. No additional qualifications or diagnosis needed to qualify for general use seat and back cushion.

Length of Need: ___________
{99 = Lifetime}

OXYGEN

- ❒ O2 _________LPM ____________
- O2 SATS ________________
- DATE OF SATS ________________
- ❒ CONCENTRATOR (E1390)
- ❒ PORTABLE (E0431)
- ❒ CANNULA
- ❒ CONTINUOUS USE
- ❒ BLEED IN
- ❒ HOURS OF SLEEP
- ❒ ON EXERTION

Length of Need: ___________
{99 = Lifetime}

ENTERAL NUTRITION

- ❒ FORMULA: ______________________
- ❒ FEEDING EXTENTSION SETS
- ❒ PUMP (B9002) BAGS (B4035)
- ❒ BOLUS (B4034)
- ❒ GRAVITY (B4036)
- CC/HR: _________________
- CANS/DAY: ______________
- CANS/DAY: ______________

Length of Need: ___________
{99 = Lifetime}

HOSPITAL BEDS

- ❒ SEMI ELECTRIC HOSPITAL BED (E0260)
- ❒ HEAVY DUTY HOSPITAL BED 350 LBS+ (E0303)
- ❒ EXTRA HEAVY DUTY HOSPITAL BED 600 LBS+
- ❒ PATIENT LIFT W/SLING (E0630)
- ❒ TRAPEZE
- ❒ GEL OVERLAY*
- ❒ ALTERNATING PRESSURE PAD*
- ❒ PRESSURE REDISTRIBUTION MATTRESS*
- ❒ THERAPUTIC 5 ZONE SUPPORT SURFACE*

*NOTE: Patient is completely immobile or has limited mobility and at least one of the four listed conditions: impaired nutritional status, fecal or urinary incontinence, altered sensory perception, and/or compromised circulatory status.

Length of Need: ___________
{99 = Lifetime}

I give permission to Med Mart to act as my agent/representative in transmitting this written prescription via fax to the provider of the patient's choice.

________________________________ Physician's Signature

________________________ Date