Hearts Enteral, LLC©
www.heartsenteral.com

DME New Order Form

Fax (973) 387-1223
Phone (973) 706-6704
Email rfranco@heartsenteral.com

THIS IS NOT A PRESCRIPTION

***REQUIRED FIELD**

Referral Contact Name_____ Phone_____ Fax_____

PATIENT INFORMATION

Patient Name (full name) * _____ **Date of Birth*** __/__/____
Gender ☐ M ☐ F Height*_____ Weight*_____ Food Allergies: ☐ None ☐ _____

Primary Phone*_____ Secondary Phone_____ Email_____
Delivery Address* Street_____ **City**_____ **State**_____ **Zip** _____

Insurance Provider: *_____ Insurance ID#_____ Group # _____

Health Plan Ph. number: _____

Secondary Insurance YES ☐ NO ☐ (if yes, please attach a copy of any secondary insurance card with this form)

Physician *_____ Phone *_____
Clinic_____ Fax _____
Email _____

ORDER

1 Order Date* ___/___/___ ☐ Initial start ☐ Revised/changed.

2 Diagnosis ICD 10*_____ _____ _____ _____
3 HCPCS Code(s)* _____ _____ _____ _____
4 Purchase ONLY No Rentals _____

5. **Product Name***_____

6 **Product Name*** _____

7 **Product Name*** _____

IMPORTANT PLEASE READ*** Please attach a copy of your ☐prescription(s), ☐insurance card(s), ☐letter of medical necessity (LMN), ☐ recent progress notes/clinical. Prescriptions must be within 30 days*, LMN must be on clinic letterhead * No other forms are allowed. If you have any questions, please contact our customer service department at (973) 706-6704.

☐ **Additional Info:** _____

If you have questions, please contact our customer service team at Hearts Enteral (973) 706-6704.By signing below, I authorize the use of this document as a pre-order and NOT a physical prescription. I understand that any medical records support the medical need for the item(s) prescribed. I also understand and agree with Hearts Enteral HIPAA Notice of Privacy Practices.

Print prescriber name* _____ **NPI #*** _____ **Tax ID#:** _____
Prescriber signature* _____ **Date*** ___/___/____