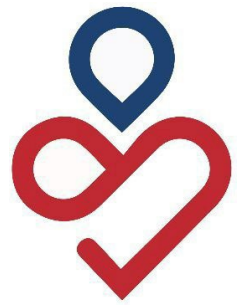




Hearts Enteral, LLC©  
www.heartsentral.com

# DME New Order Form

Fax (973) 387-1223  
Phone (973) 706-6704  
Email [rfranco@heartsentral.com](mailto:rfranco@heartsentral.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 \* \_\_\_\_ / \_\_\_\_ / \_\_\_\_