



DME Standard Written Order

FAX: 281-822-3083

Please fax this completed form along with a physician Rx and associated progress notes to. Lack of clinical information may result in delayed processing. *Indicates Required Field

PATIENT INFORMATION

First Name:		Last Name:		M.I.	Phone:	
Address:			City:		State:	Zip:
DOB:	Gender:	Ht:	Wt:	Social Security #:		
Emergency Contact/Resp Party:				Phone:		
Address:			Email:			

INSURANCE INFORMATION

Primary Ins: <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other			Secondary Ins: <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other			
Name:			Name:			
Member ID #:			Member ID #:			

DIAGNOSES / ICD-10 CODES

Dx 1:	Dx 2:	Dx 3:	Dx 4:
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EQUIPMENT NEEDED: (Check Items)

<input type="checkbox"/> Power Wheelchair	<input type="checkbox"/> Back Brace/Lumbar Support	<input type="checkbox"/> Trapeze Bar
<input type="checkbox"/> Manual Wheelchair	<input type="checkbox"/> Lymphedema Pump & Garment	<input type="checkbox"/> Patient Lift
<input type="checkbox"/> Rollator (walker w/wheels & seat)	<input type="checkbox"/> Low Air loss Mattress – Ulcer Stage:	<input type="checkbox"/> Shower Chair
<input type="checkbox"/> Walker <input type="checkbox"/> Walker w/Wheels	<input type="checkbox"/> Gel Overlay	<input type="checkbox"/> Standing Frame
<input type="checkbox"/> Wheelchair Cushion	<input type="checkbox"/> Hospital Bed	<input type="checkbox"/> Repairs
<input type="checkbox"/> Scooter (Only 3-whl, 300 wt cap available)	<input type="checkbox"/> Other	

PHYSICIAN INFORMATION

Name:		NPI#:		
Address:		City:	State:	Zip:
Referral Contact:		Phone:	Fax:	

**PLEASE FAX Rx w/ICD-10 CODES & PROGRESS NOTES
ALONG WITH THIS REFERRAL FORM TO FAX NUMBER ABOVE**