

Physicians Order - Medicare

DETAILED WRITTEN ORDER FOR DURABLE MEDICAL EQUIPMENT

Prescriber's Name
(Print)

REQUIRED

NPI

REQUIRED

Order Date

REQUIRED

Prescriber's Signature **X**

STAMPED SIGNATURE NOT ACCEPTED

Signature Date

REQUIRED

Please sign, date and fax back to Forester Family Medical Supply.

PATIENT INFORMATION

Patient Name

DOB

Diagnosis Codes:

Phone#:

Height:

WT:

Next of Kin

Phone#:

DURABLE MEDICAL EQUIPMENT

Items being order for Patient:

Estimate time of need (1-99 months)

Lifetime = 99

- | | | | |
|----|-------|--------|-------|
| A) | _____ | HCPCS: | _____ |
| B) | _____ | HCPCS: | _____ |
| C) | _____ | HCPCS: | _____ |
| D) | _____ | HCPCS: | _____ |
| E) | _____ | HCPCS: | _____ |
| F) | _____ | HCPCS: | _____ |
| G) | _____ | HCPCS: | _____ |
| H) | _____ | HCPCS: | _____ |
| I) | _____ | HCPCS: | _____ |
| J) | _____ | HCPCS: | _____ |

Forester Family Medical Supply, Inc
4061 South Eliot Street • Englewood, Colorado 80110
Telephone: (303) 558-0438 • Facsimile: (303) 593-1862