

T.E.N.S

Unlimited INC.

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Durable Medical Equipment

FAX TO: (808) 200-0391

PATIENT INFORMATION:

PATIENT NAME: _____ DOB: ___/___/___ ORDER DATE: ___/___/___

PHONE: ___-___-___ ADDRESS: _____ CITY: _____ STATE/ZIP: _____

*****PLEASE PROVIDE PATIENT DEMOGRAPHIC*****

ORDER INFORMATION

____ STANDARD ELECTRIC BREAST PUMP (E0603) DX: _____

____ Hospital grade breast pump (E0604) DX: _____

____ Length of need _____ DX: _____

____ (2 TUBING, 2 CAPS, 2 BOTTLES, 2 BREAST SHIELDS, 6 VALVES/MEMBRANES, MILK BAGS)

____ Post-partum garment DX: _____

____ Compression socks (QTY ___ A6531) DX: _____

____ Pelvic support brace DX: _____

____ Maternity Support Belt DX: _____

____ Prenatal Cradle (V-sling) DX: _____

____ C- Section Kits (QTY ___ A6212 QTY ___ A5245) DX: _____

____ Additional product _____ DX: _____

I certify that I am the physician identified in this form. I have reviewed the detailed written order. I certify that the medical necessity information is true, accurate, and complete to the best of my knowledge. I will provide medical documentation to help with the **DME** processing. I acknowledge that the patient is aware that **DME** may contact them for any additional information to process this order. A copy of this order will be retained as a part of the patient's medical record.

REQUESTING PHYSICIAN INFORMATION

Physicians Name: _____ NPI: _____

Signature: _____ Signed Date: ___/___/___

Contact Phone: ___-___-___ Contact Fax: ___-___-___

Address: _____ City: _____ State/Zip: _____