T.E.N.S

Unlimited INC.

Phone: (808) 722-0226
Email: Hawaii@tensunlimited.com
Web: Tensunlimited.com

Durable Medical Equipment

FAX TO: (808) 200-0391

650 Iwilei Rd. #290
Honolulu, HI 96817

PATIENT INFORMATION:

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

ADDRESS: _____ CITY: _____ STATE/ZIP: _____

PHONE: _____-_____-_____ EMAIL: _____ INSURANCE NAME: _____

EDD: ___/_____/_____ WKS GESTATION: _____ MEMBER ID: _____

____**Standard Electric breast pump (E0603)**	**DX: Z39.1**
____**Hospital grade breast pump (E0604)** Length of need _____	DX: _____
____ **(2 Tubing, 2 CAPS, 2 bottles, 2 breast shields, 6 valves/membranes, milk bags)**	
___ Post-partum garment (L2640) QTY: ____ Size: XS SM M L XL 2XL	DX: M62.08
___ Compression socks (A6531) QTY: ___ Size: XS SM M L XL 2XL	DX: R60.9
___ Pelvic support brace (L0621) Size: XS SM M L XL 2XL	DX: R10.2
___Prenatal Cradle (V-sling) (L8310) QTY: ___ Size: XS SM M L XL	DX: O22.00
___C- Section Kits (QTY ____ A6212 QTY_____ A5245)	DX: O90.0
___Compression System (E0652**)**	**DX: R60.9**
___ Replacement Cuff (RT and RT) (E0667)	**DX: R60.9**

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: _____