## **FAX TO: (808) 200-0391**

|  |
| --- |
| **Patient information:** PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ dob: \_\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ order date: \_\_\_/\_\_\_\_/\_\_\_\_\_\_  address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_city: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE/zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone: \_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_ EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **\*\*\*\*\*\*\*\*\*Please provide demographic and office notes for processing\*\*\*\*\*\*\*\*\*\*** |

|  |
| --- |
| **Order Information****BRACING**  **THERAPIES: MOBILITY SUPPORTS:**\_\_\_\_ OA Knee Brace L1820 \_\_\_\_ TENS Unit E0730 \_\_\_\_ Crutches (Sizes: Y M L) E0114 \_\_\_\_ Post- OP ROM Brace L1833 \_\_\_\_ EMS Unit E0745 \_\_\_\_ Walker w/ 2 wheels & bag E0143 \_\_\_\_ Pneumatic walking boot \_\_\_\_ Bone growth stimulator E0747 \_\_\_\_ Heavy duty knee walker E0118\_\_\_\_ Back brace L0648 \_\_\_\_ Pneumatic compression devices E0675\_\_\_\_ Conductive garment E0731 \_\_\_\_ Electric Scooter\_\_\_\_ Other please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**TENS/EMS Unit Supplies:**\_\_\_\_\_ Lead Wire \_\_\_\_\_ Electrodes \_\_\_\_\_ Battery \_\_\_\_\_\_ Conductive spray \_\_\_\_ Adhesive remover |

|  |
| --- |
| 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: \_\_\_\_\_\_\_\_\_\_\_\_\_ |