DME/Medical Supplies Physician Order Form

This order form cannot be accepted beyond 90 days from the date of the physican's signature. Fax completed form to 704-781-5502.

Section A: Requested Durable Medical Equipment and Supplies

This section was completed by (check one): □ Requesting Physician □ Other: _____

Patient name:	Patient DOB: / /
Patient Insurance & ID#:	Is Patient under 21 years of age? YES □ NO □
Patient SSN:	Patient address:
Patient Telephone:	Patient Email:
Provider NPI:	Other:
Other:	Other:
Physician name:	Physician telephone:

Patient Living Status:
Supplier Benefit Code:
Other:
Physician Fax:

I certify that the DMEPOS being requested under this order is consistent with the physician's determination of medical necessity and prescription. The prescribed items are appropriate and can safely be used in the client's home when used as prescribed.

Provider representative signature: Date: / /

Provider representative name (Typed or Printed):

Item Number	HCPCS Code (if known)	Description of DME/medical supplies	Quantity (Number)	Each, Box, Case	Prior authorization required?	Is this the first order of this item*?	Custom item?[1]
1					□ Y □ N	□ Y □ N	□ Y □ N
2					□ Y □ N	□ Y □ N	□ Y □ N
3					□ Y □ N	□ Y □ N	□ Y □ N
4					□ Y □ N	□ Y □ N	□ Y □ N

1. If "Yes," additional documentation must be provided to support determination of medical necessity.

□ Check if additional docs attached.

*Has patient received this item before? YES □ NO □ If yes, did insurance cover it:

Section B: Diagnosis and Medical Need Information

This is a prescription for DME/supplies and must be filled out by the prescribing physician.

Item Number[2] (From Section A)	ICD-10	Brief Diagnosis Descriptor	Complete justification for determination of medical necessity for requested item(s)[2] (Refer to Section A, footnote 1)
	_ _ _ . _ _		
	_ _ _ . _ _		
	_ _ _ . _ _		
	_ _ _ . _ _		

2. Each item requested in Section A must have a correlating diagnosis and medical necessity justification.
Enter all *Item numbers* from the table in Section A that pertain to each diagnosis.

If applicable, include height/weight, wound stage/dimensions and functional/mobility status in table below.

Height	Weight	Wound stage/dimensions	Functionality/mobility status

***Note**: The "Date last seen" and "Duration of need" items below **must** be filled in.*

Date last seen by physician: / /

Duration of need for DME: _____ month (s) Duration of need for supplies: _____ month (s)

By signing this form, I hereby attest the information completed in Section "A" is consistent with the determination of the patient's current medical necessity and prescription. By prescribing the identified DME and/or medical supplies, I certify the prescribed items are appropriate and can safely be used in the client's home when used as prescribed.

Signature and attestation of prescribing physician: Date: / /

Signature stamps and date stamps are not acceptable

Prescribing physician's license number:

Prescribing physician's Taxonomy: Prescribing physician's NPI:

□ Check if all of the information in Section A was complete at the time of the prescribing provider signature