DURABLE MEDICAL EQUIPMENT ORDER

PLEASE PRINT

Order Date:_____

PATIENT INFORMATION:

Patient Name: _____ **Date of Birth:** _____

Address (include apt#): _____

Diagnosis(s):(Include ICD10)_____

Height: _____ **Weight:** _____

Please provide patient's demographic information & insurance cards

INSURANCE:

Primary Insurance: _____ Policy/ID: _____

Group# _____ Phone: _____

Secondary Insurance: _____ Policy/ID: _____

EQUIPMENT Details:

Straight Cane ☐ Quad-Cane ☐ Crutches ☐

Walker without wheels ☐ Walker with 5" front wheels ☐

Rollator walker ☐ *(upgrade fee will apply to all rollator orders)*

Bedside Commode ☐ Drop-arm Commode ☐ Heavy Duty Commode ☐

Is the beneficiary Room confined? _____

Is the beneficiary Floor confined without a bathroom? _____

Will this equipment be used at the bedside? _____

Semi-electric Hospital Bed ☐

Full-electric Hospital Bed ☐ *(upgrade fee will apply to all Full-electric bed orders)*

Heavy Duty Hospital Bed ☐ *(350 lbs. to 600 lbs.)* Bariatric Hospital Bed ☐ *(over 600 lbs.)*

Full side rails ☐ Half side rails ☐

Mattress gel over-lay ☐

Low-air loss mattress ☐

(Additional nursing, wound care notes and forms will be required for all support surface orders)

Physician Information:

Ordering Physician: (PRINT)_____

Phone: _____

Physician Signature: _____ Date: _____

NPI: _____ Fax Number: _____

Length of need: _____1-99 (99=Lifetime)

DELIVERY ADDRESS IF DIFFERENT FROM PATIENT'S HOME ADDRESS:

_____

Anticipated discharge date:_____