1020 Palm Parkway
Weslaco, TX 78596
Phone 866.969.9596
Fax 956.969.9569

DME PHYSICIAN'S ORDER FORM

PLEASE COMPLETE THE FOLLOWING INFORMATION LEGIBLY. EFFECTIVE DATE: _____ LENGTH OF NEED: _____

PATIENT NAME: _____ DOB: _____ HT: _____ WT: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ SEX: ☐ MALE ☐ FEMALE

PATIENT ID NUMBER (POLICY NUMBER) _____

PATIENT SECONDARY INSURANCE ID NUMBER _____

DIAGNOSIS: _____

REPIRATORY ITEMS:
☐ E0570 NEBULIZER W/MASK(A7015) TUBING(A7003)

WALKING AIDS:
☐ E0105 QUADCANE
☐ E0114 CRUTCHES
☐ E0135 FOLDING WALKER (INCLUDES HEMI)
☐ E0143 WALKER W/ WHEELS
  ☐ E0156 SEAT ATTACHMENT
  ☐ E0154 PLATFORM ATTACHMENT
☐ E0149 HEAVY DUTY WALKER W/WHEELS

BED & PATIENT ROOM ACCESSORIES:
☐ E0260 HOSPITAL BED
☐ E0185 GEL/ MATRESS OVERLAY (STG. I)
☐ E0277 ALT. AIR MATTRESS (STG. II)
☐ E0163 BEDSIDE COMMODE (3 IN 1)
☐ E0910 TRAPEZE BAR FOR HOSPITAL BED
☐ E0630 HOYER LIFT

WHEELCHAIRS & ACCESSORIES:
☐ K0001 STANDARD WHEELCHAIR
☐ K0003 **LIGHTWEIGHT** WHEELCHAIR
☐ K0004 HIGH STRENGTH WHEELCHAIR
☐ K0007 HEAVY DUTY WHEELCHAIR (>300LBS)
(CHECK ALL ACCESSORIES THAT APPLY)
☐ K0195 **ELEVATING LEG RESTS**
☐ (EXTRA WIDE) NONSTANDARD SEAT FRAME
  ☐ E2201 **20 INCH WIDTH** SEAT FRAME
  ☐ E2201 **22 INCH WIDTH** SEAT FRAME
  ☐ E2202 **24 INCH WIDTH** SEAT FRAME
☐ E2601 GENERAL WHEELCHAIR **SEAT** CUSHION
☐ E2611 GENERAL WHEELCHAIR **BACK** CUSHION

MEDICAID ONLY ITEMS (TITLE XIX REQUIRED):
☐ SHOWER CHAIR
☐ TOILET LIFT W/ RAILS
☐ TUB TRANSFER BENCH
☐ INCONTINENCE SUPPLIES
(DIAPERS, PULL UPS, UNDERPADS, LINERS, WIPES, OINTMENT)

LOWER EXTREMITY SUPPORT:
☐ L1902 AFO, ANKLE GAUNTLET BRACE
☐ L1930 AFO, PLASTIC, PREFABRICATED
☐ L4360 WALKING BOOT, PNEUMATIC
☐ L1810 KNEE ORTHOSIS, ELASTIC W/JOINTS
☐ L1820 ELASTIC KO W/ CONDYLAR PADS
☐ L1830 KNEE SPLINT/IMMOBILIZER
☐ L1832 TROM BRACE, KO, ADJ. KNEE JOINTS
☐ OTHER: _____

LUMBAR SUPPORT:
☐ L0627 LUMBAR BACK SUPPORT BRACE
☐ L0631 LSO, BACK SUPPORT BRACE
☐ L0637 LSO, BACK SUPPORT W/ADD. PROFILE
☐ OTHER: _____

UPPER EXTREMITY SUPPORT:
☐ L3908 WRIST IMMOBILIZER, PREFABRICATED
  ☐ L3807 W/ THUMB IMMOBILIZATION
☐ L3760 HINGED ELBOW SUPPORT BRACE
☐ L3670 ARM SLING, ROM CONTROL &SUPPORT
☐ L3675 SHOULDER IMMOBILIZATION/STABILZER
☐ OTHER: _____

MISCELLANEOUS:
☐ OTHER: _____

I, the undersigned, certify that the above prescribed equipment/medication is MEDICALLY NECESSARY for this patient's well being. In my opinion, the equipment is both reasonable and necessary in reference to accepted standards of medical practice and treatment of this patient's condition and has not been prescribed as "convenience equipment".

PHYSICIAN'S SIGNATURE: _____ DATE: _____

PHYSICIAN'S NAME: _____ NPI #: _____ PHONE #: _____

ADDRESS: _____ CITY, STATE, ZIP: _____