Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form

See instructions for completing Title XIX Home Health Durable Medical Equipment (DME)/Medical Supplies Physician Order Form. This order form cannot be accepted beyond 90 days from the date of the physician's signature.

		ted Durable Medical Ed mpleted by (check one):		•	plier							
			Client	Informat	tion							
Client Nam												
			Supplie	er Informa	ation		•					
Name:				Telep	ohone:		Fax	numbe	er:			
Address:												
TPI:		NPI:	Taxonoi	my:			Benefi	it Code	:			
QRP name:			Q	RP TPI:			QRP	NPI:				
		vices being supplied und								ecessity a	nd	
		escribed items are appro	•	y be used	in the client's			s pres	cribed.			
		es provider representative s		IV		L	Date: /		/			
DME/meaid	cal supplie	es provider representative r										
			Prescribing P	hysician I	nformation	1-						
Name:	··cncc	Descripti	Telephone:	Quantity Price			Fax number:					
Item Number	HCPCS Code	•	escription of nedical supplies		y Price	Prior authorization required?		Beyond quantity limit? ¹			Custom item? ¹	
1				1		□ Y	□ N	□ Y	□ N	пΥ	□ N	
2				1		□Y	□ N	□Y	□ N	пΥ	□ N	
3				1		□ Y	□ N	□ Y	□ N	υΥ	□ N	
4				1		ΒY	□N	□ Y	□ N	пΥ	□ N	
	-1-1:±: op of	L moust be n	ام معرض معرض المعادد ا	tinati	f dical			_				
		documentation must be p		eterminau	on of medical	necess	sity.					
	_	sis and Medical Need II In for DME/supplies and mus		prescribir	ng physician.							
Item Number ² (From Section A)	ICD-9	Brief Diag	Brief Diagnosis Descriptor			Complete justification for determination of medical necessity for requested item(s) ² (Refer to Section A, footnote 1)						
		-										
	<u> </u>	=										
2 Foods itom		_		a a a d a a a d	ical magazituri	:a+:£:a	ation					
	•	ed in Section A must have a pers from the table in Sectio	5 5					ne ente	red			
		e height/weight, wound sta	·				Idilibera may s	CCITE	icu.			
	•		J		ŕ							
Note: The "	Date last	seen" and "Duration of ne	ed" items <u>must</u> be fill	led in.	Date last s	seen by	y physician:	/	/			
Duration of			• •		n of need for s				nth (s)			
my signatur	re and is co	hereby attest that the inform ensistent with the determina tify the prescribed items are	tion of the client's curr	ent medica	I necessity and	l prescr	iption. By pres	cribing	the ider			
_		ation of prescribing physicia		<u> </u>				ite:	/	/		
Signature a												
Signature a				s and date s	stamns are not	accent	ahle					
		s license number:	Signature stamp	s and date s	stamps are not	accept	able					