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. Fax completed form to 1-512-514-4209.

	-	d Durable Medic											
							upplier						
Client nam		Client date of birth:											
	dicaid number					Is clien	t under	21 years	of age?	YES	NO		
Supplier na			1	er address:		1 -							
Supplier telephone:			Supplier Fax: Supplier										
Supplier N			Supplier Taxonomy:				Supplier Benefit Code:						
QRP name:			QRP TPI:				QRP NPI:						
Physician r			Physician tele	<u>'</u>	141 41 1 1		ician Fa			•-			
-		s being supplied und ibed items are appro								essity and	1		
		ovider representative	-	surery be used	a in the thene	Date		a us preser	ibcu.				
		ovider representative		Printed)·		Date	•						
Item	HCPCS Code				Price	Prio	r	Beyond		Custo			
Number		DME/m	nedical	3		authorization		quantity		item?¹			
		supp	olies			requir	ed?	limit					
1						Y	N	Y	N	Y	N		
2						Y	Ν	Υ	Ν	Υ	Ν		
3						Y	N	Υ	N	Υ	N		
4						Y	N	Υ	N	Υ	N		
1 If "Vos "	additional doc	umentation must be	nrovided to sunn	ort determina	tion of medica	al necessity							
		umentation is attache			tion of medica	arriceessity.							
	Provider Medi		NO										
					s, indicate Me	dicare numi	ber:						
	_	s and Medical Ne				•							
_	rescription for		ME/supplies and must be filled out by the prescribing				Complete justification for determination of						
Item Number ²	ICD-9	ICD-9 Brief Diagnosis Descriptor				medical necessity for requested item(s) ²							
(From					(Refer to Section A, footnote 1)								
Section A)													
2. Each ite	m requested in	Section A must have	a correlating dia	gnosis and me	dical necessity	y justificatio	n.						
Enter all	ltem numbers f	rom the table in Secti	on A that pertain	to each diagn	osis.								
If applicab		ght/weight, wound st		and functiona	1								
Height	Weight	Wound stage/dimer	nsions		Functional	ity/mobility	y status						
Note : The "	Date last seen"	and "Duration of need	" items below mus	st be filled in.									
Date l	ast seen by ph	/sician:											
Durati	ion of need for	DME:	month (s)	Dur	ation of need	for supplies	:	m	onth (s)				
, , ,		ereby attest that the		•									
		ty and prescription. ely be used in the cli				medical sup	plies, I	certify the	prescri	bed item	s are		
Signature and attestation of prescribing physician:								Date:					
J /			Signature stamp	os and date st	amps are not	acceptable	<u> </u>						
Prescribing	physician's lice	nse number:				-							
Prescribing	physician's TPI	:		Presc	ribing physici	an's NPI:							
_		nation in Section A wa					turo						