DOUBEK medical supply

TF: 800.368.2358
F: 708.293.1144
doubekmedical.com

Referral Name: _____

Referral #: _____

DME Fax Order Form

PATIENT INFORMATION

Order Date: _____

Patient Name: _____ Date of Birth: _____

Address: _____

Email Address: _____ Phone #: _____

DME Fax Order Form

Medicare has implemented the requirement for patient Face to Face (F2F) visit prior to dispensing DME. Suppliers are required to obtain chart notes from the visit AND obtain a written order PRIOR to delivery that consists of the item AND:

1) Patient Name 2) Date Prescribed 3) Physician Signature 4) NPI 5) WOPD

DURABLE MEDICAL EQUIPMENT - Diagnosis _____ **Height** _____ **Weight** _____ **Length of Need** _____

Ambulatory Devices: ☐ Cane (E0100) ☐ Crutches (E0114) ☐ Quad cane (0105)
☐ Walker up to 300 lbs (E0135) ☐ Wheels (E0143) ☐ 3 inches ☐ 5 inches
☐ Extra Wide Walker 300-450 lbs (E0148) ☐ Heavy Duty Walker with Wheels ›350 lbs (E0149)
☐ Junior Walker with Wheels (E0143) ☐ Rollator with Seat and Wheels (E0143 & E0156)
☐ HD Rollator with Seat and Wheels (E0149 & E0156)

Wheelchairs: (up to 250 lbs) ☐ Standard (K0001) ☐ Light Weight (K0003) ☐ Transport ‹300 lbs (E1038)
☐ Geri Chair (E0131) ☐ Heavy Duty Wheelchair 250-300 lbs (K0006 & K0007)
☐ Heavy Duty Transport Chair ›300 lbs (E0139)

Wheelchair Accessories: ☐ Elevating Leg Rests (K0195) ☐ Footrest (E1130)

Beds: ☐ Semi-Electric Hospital Bed (E0260) ☐ Heavy Duty Full Electric 350-600 lbs (E0301)

Bed Accessories: ☐ Rails Half ☐ Rails Full ☐ Trapeze (E0910) ☐ Free Standing (E0940) ☐ HD Trapeze (E0912)
☐ Patient/Hoyer Lift Maximum Capacity 450 lbs (E0630)

Support Surfaces: ☐ Alternating Pressure (E0181) ☐ Low Air Loss System (E0277) **WOUND ASSESSMENT REQUIRED.**

Aids to Daily Living: ☐ Bedside Commode (E0163) ☐ Drop Arm Commode (E0165) ☐ HD Commode (E0168)
1. The patient is confined to a single room? Y or N
2. The patient is confined to one level of the home environment and there is no toilet on that level? Y or N
3. The patient is confined to the home and there are no toilet facilities in the home? Y or N

☐ Shower Chair ☐ Back ☐ No Back (E0245) *Medicaid only covers one without a back.*

☐ Tub Transfer Bench (not covered item)

DME: _____

PRESCRIBING PHYSICIANS INFORMATION

Physician Name: _____ NPI: _____

Physician Signature: _____ Date: _____

Physician Phone #: _____ Fax #: _____