

DME ORDER FORM

PHONE: 718-436-6088 • FAX: 718-436-3649 • EMAIL: DMEORDERS@MEDARTS.NET

ADDRESS: 5504 13TH AVE BROOKLYN, NY 11219

PATIENT INFORMATION

FIRST NAME:		LAST NAME:		
DOB:	GENDER:	HT:	WT:	WAIST/HIP:
ADDRESS:		CITY:	STATE:	ZIP:
HOME PHONE:		CELL PHONE:	E-MAIL:	
EMERGENCY CONTACT:		RELATION:	PHONE:	

INSURANCE INFORMATION

PRIMARY INSURANCE NAME:	SECONDARY INSURANCE NAME:
PRIMARY INSURANCE ID:	SECONDARY INSURANCE ID:
MEDICAID ID:	

MANUAL WHEELCHAIR (SEE REVERSE SIDE FOR REQUIRED DOCUMENTATION)

LENGTH OF NEED: _____ (99=lifetime) DATE OF FACE TO FACE: _____ ICD-10: _____

HOW MANY HOURS PER DAY WILL PATIENT SPEND IN THE WHEELCHAIR? _____ (Select One below)

☐ **STANDARD** - PATIENT UP TO 250 LBS
 ☐ **HEAVY DUTY** - PATIENT OVER 250 LBS
 ☐ **X-HEAVY DUTY** - PATIENT OVER 300 LBS
☐ **LIGHTWEIGHT** - UNABLE TO SELF-PROPEL IN STANDARD WHEELCHAIR BUT CAN IN LIGHTWEIGHT WHEELCHAIR
☐ **TRANSPORT CHAIR** - NO ACCESSORIES ARE COVERED WITH A TRANSPORT CHAIR

WHEELCHAIR ADD-ONS/ACCESSORIES (covered by insurance)

☐ ELEVATING LEG RESTS	☐ POSITIONING SEAT BELT	☐ FULLY RECLINING BACK
☐ FOAM SEAT CUSHION	☐ HEAD REST - for use with reclining back	☐ BRAKE EXTENSIONS
☐ BACK CUSHION	☐ ANTI-TIPPERS	

MOBILITY

ICD-10: _____

☐ CANE - STRAIGHT
 ☐ QUAD CANE NARROW
 ☐ QUAD CANE WIDE
☐ WALKER - NO WHEELS
 ☐ WALKER WITH WHEELS
 ☐ ROLLATOR WITH WHEELS & SEAT

HOSPITAL BED & SICK ROOM (SEE REVERSE SIDE FOR REQUIRED DOCUMENTATION)

LENGTH OF NEED _____ (99=lifetime) DATE OF FACE TO FACE _____ ICD-10: _____

☐ SEMI ELECTRIC HOSPITAL BED WITH RAILS & MATTRESS
 ☐ PATIENT LIFT (HOYER LIFT)
☐ BARIATRIC BED WITH RAILS & MATTRESS - patient over 350 lbs
 ☐ COMMUNE

HOSPITAL BED ADD-ONS/SUPPORT SURFACES (covered by insurance)

☐ GEL OVERLAY ☐ AIR PAD OVERLAY ☐ EGGCRATE OVERLAY ☐ ALTERNATING PRESSURE PUMP (APP)	CHECK ALL THAT APPLY: Patient ☐ is completely immobile ☐ is partially immobile ☐ has ulcers AND ☐ has impaired nutritional status ☐ is incontinent ☐ has altered sensory perception ☐ has compromised circulatory status
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BATHROOM SAFETY (Medicaid only)

ICD-10: _____

☐ BATH BENCH WITH BACK
 ☐ TRANSFER BENCH
 ☐ GRAB BAR (specify 1 or 2)
☐ BATH BENCH without BACK
 ☐ RAISED TOILET SEAT
 ☐ TOILET SAFETY FRAME (VERSAFRAME)

CERTIFICATE OF MEDICAL NECESSITY

I certify that the items ordered above are medically necessary for my patient and I attest to the fact that I have no financial relationship with the DME supplier

Physician Name: _____ NPI #: _____ Phone #: _____

Address: _____ Fax #: _____

Physician Signature: _____ Date: _____

FAX FORM TO 718-436-3649 OR SEND ELECTRONIC PRESCRIPTION DIRECTLY FROM YOUR EMR SYSTEM OR FROM PARACHUTE HEALTH

WHEELCHAIR REQUIRED DOCUMENTATION

All wheelchair orders must include clinical notes documenting a face-to-face examination conducted within the past 6 months. The documentation must:

1. Confirm that the patient was evaluated specifically for wheelchair needs.
2. State that the wheelchair is required for use IN THE HOME.
 - Per Medicare guidelines, use for outside the home (e.g for medical appointments) **does not** meet coverage criteria for a wheelchair
3. Describe the condition that necessitates a wheelchair AND explain why a cane or walker is insufficient.
 - Include history of condition, diagnoses, symptoms, progression and prognosis
 - Include details such as how far the patient can ambulate with a cane or walker and why those devices do not adequately meet the patient's mobility needs.
4. Include physical exam relevant to mobility devices
 - Cardiopulmonary, musculoskeletal (arm and leg strength, ROM and endurance) and neurological (gait, balance and coordination)
5. Indicate the patient's willingness to use the wheelchair and whether the patient has the physical and mental ability to self-propel or will have a caregiver available to assist with the wheelchair.

Additional required documentation for wheelchair options and/or accessories

1. **Lightweight Wheelchair** – document that the patient cannot self-propel a standard wheelchair but can and does self-propel in a lightweight wheelchair.
2. **Seat Belt** – indicate the need for proper positioning due to upper-body instability, weakness or spasticity
3. **Elevating Leg rests** – Indicate the patient has edema of extremities OR a musculoskeletal condition or brace that prevents knee flexion OR is receiving a reclining back wheelchair
4. **Reclining Back** – indicate that the patient is unable to perform functional weight shifts and is at high risk for pressure ulcers OR the patient utilizes bladder catheterization and cannot transfer to a bed.
5. **Transport Chair** – elaborate as to why a standard wheelchair is not sufficient (ease of use for outdoors, e.g, to put in a car, is not an acceptable justification, in-home use is the only acceptable justification).

HOSPITAL BED REQUIRED DOCUMENTATION

All hospital bed orders must include clinical notes documenting a face-to-face examination conducted within the past 6 months. The documentation must:

1. Confirm that the patient was evaluated specifically for hospital bed needs.
2. Provide a detailed description of the medical condition requiring a hospital bed, including the necessity for positioning that cannot be achieved with a standard bed such as
 - Elevating the head of the bed more than 30 degrees due to CHF, CPD or aspiration risk
 - Positioning to alleviate pain
 - Use of traction equipment that can only be attached to a hospital bed
3. Indicate the patient requires adjustable bed height to perform transfers to a chair or a standing position
4. Document the patient's need for frequent and immediate changes in body position
5. Confirm that the patient can operate the hand control

PATIENT LIFT REQUIRED DOCUMENTATION

All patient lift orders must include clinical notes documenting a face-to-face examination conducted within the past 6 months. The documentation must:

1. Describe the medical condition requiring the patient lift and specify that the lift is necessary to transfer the patient between a bed, chair or commode.

SUPPORT SURFACES REQUIRED DOCUMENTATION

All support surface orders must include clinical notes documenting a face-to-face examination conducted within the past 6 months. The documentation must:

1. Provide a detailed description of the medical condition requiring the support surface
2. Specify all applicable conditions (see criteria below)
 - Immobile **OR** patient has ulcers,

AND

 - Impaired nutritional status **OR** incontinence **OR** altered sensory impaired **OR** compromised circulatory status