

Prescription: Durable Medical Equipment

STEP 1 | PATIENT INFORMATION (PLEASE PRINT LEGIBLY).

PLEASE INCLUDE PATIENT'S FACE SHEET WHEN FAXING TO 717-399-8128.

Patient Name _____ Discharge Date _____
 DOB _____ Height _____ Weight _____ Phone: _____ E-mail _____
 Address: _____ City _____ State _____ Zip _____
 Insurance Policy: _____ Policy ID: _____

STEP 2 | DIAGNOSIS Primary _____ Secondary _____ Other _____

STEP 3 | DME PRESCRIPTION

WHEELCHAIRS

- Standard Wheelchair (K0001)
- Lightweight Wheelchair (K0003)
- Hi-Strength Lightweight Wheelchair (K0004)
- High-Back Reclining Wheelchair (K0001 & E1226)
- Heavy Duty Wheelchair (K0006-K0007)
- Hemi Height 17.5
- Super Hemi 15.5
- Other _____

WHEELCHAIR WIDTH/ DEPTH

W: 16" 18" 20" 22" 24"

D: 16" 18" 20"

WHEELCHAIR ACCESSORIES

- Seat Cushion/ Back Cushion
- Swing Away Footrests
- Swing Away Elevating Leg Rests
- Seat Belt 48" or 60"
- Wheel-Lock Extensions
- Pull-to-Lock Wheel Locks
- Anti-Tippers
- Other _____

BARIATRIC (300+ lbs.)

- Rollator (E0149, E0156)
- Walker without wheels (E0149)
- Other _____

BEDS

- Hospital Bed Semi Electric - no rails (E0260)
- Hospital Bed Fully Electric - no rails (E0265)
- Hospital Bed Semi-Electric w Mattress & rails (E0260)
- Bari Full-Electric Bed (E0303)
- Gel Foam Mattress for Std Hosp Bed (E0185)
- Other _____

MOBILITY

- Walker with Wheels (E0143)
- Hemi Walker (E0135)
- Heavy Duty Walker w/ Wheels (E0149)
- Rollator (E0143, E0156)
- Quad Cane (E0105)
- Cane (E0100)
- Adult Crutches (E0114)
- Jr. Crutches (E0114)
- Other _____

PATIENT LIFT

- Manual Hoyer Lift (E0630)
- Electric Hoyer Lift (E0635)

ALERT ALARM

- Life Alert (W1895)

RESPIRATORY

- Nebulizer (E0570)
- Oxygen E-Tank (E0431)
- Concentrator (E1340)
- CPAP/ APAP (E0601) w/ Humidifier (E0562)
Pressure _____
- BiPAP without backup rate (E0470) w/ Humidifier (E0562)
Pressure _____
- BiPAP with backup rate (E0471) w/ Humidifier (E0562)
Pressure _____
- Other _____

CPAP/ BiPAP MASK:

- Nasal Mask w/ Headgear
- Full Face Mask w/ Headgear

BATHROOM SAFETY

- Bath Bench Chair (E0240)
- Transfer Bench (E0247)
- Commode (E0163)
- Drop Arm Commode (E0165)
- Drop Arm Commode X-Wide (E0168)
- Elevated Toilet Seat w/ Arms (E0244)
- Other _____

STEP 4 | LENGTH OF NEED (REQUIRED)

Length of need _____ # of months (1 to 99 months | 99 months = lifetime)

STEP 5 | PHYSICIAN INFORMATION

Attending Physician Name (Printed) _____ Date _____
 Physician Signature _____ NPI Number _____

PATIENT QUESTIONS

1. Has this patient had this equipment before? Yes No. If yes, when? _____
2. Is patient room/bed bound? Yes No
3. Is patient's bathroom located on a floor they can access? Yes No
4. Does patient have mobility limitation that significantly impairs ability to participate in one or more Mobility Related Activities of Daily Living (MRADLs) – such as toileting, feeding, dressing, grooming and bathing in the home? Yes No
If yes, please explain: _____
5. Any other conditions that limit the patient's ability to participate in MRADLs at home? Yes No
If yes, please list applicable conditions: _____