spring park home medical equipment

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DME ORDER FORM

Patient Name:_____DOB:_____Height_____Weight____

Primary Insurance Provider_____Policy Number_____

Secondary Insurance Provider_____Policy Number_____

Length Of Need_____(if lifetime, Use 99)

EQUIPMENT

☐Standard Wheelchair(K0001) ☐Standard Hemi Wheelchair(K0002) ☐Lt Wt Wheelchair(K0003)

☐Heavy Duty Wheelchair(K0006) ☐Transport Chair(E1038) ☐Standard Power Chair(K0816)

☐Heavy Duty Power chair(K0825) ☐Elevating Leg Rest(E0990) ☐Anti Tippers(E0971)

☐Seat Cushion under 22in(E2624) ☐Seat Cushion over 22in(E2625) ☐Back Cushion Under 22in(E2606)

☐Back Cushion Over 22in(E2607) ☐Seat Belt(E0978) ☐Rolling Walker

☐Rolling Walker W/Seat(E0143-E0156) ☐Commode(E0163) ☐Semi Electric Bed(E0260)

☐Bariatric Bed(E0301) ☐Nebulizer(E0570) ☐ Other_____

Please Provide Face to Face Chart notes That Support the Medical Necessity with The Order

I hereby certify that the services are medically necessary and are authorized by me. The patient is under my care and needs the services listed.

Physician's Printed Name_____NPI:_____Fax_____

Physician's Signature:_____Signature Date_____

Medicare Requires the Signature and Signature Date to be Completed by a PECOS enrolled MD, DO, PA, NP, or CNS