



DME Order Form

Referral Source:	Consultant: Jay Buinicky
Phone #	Phone #

Patient Demographics

Name:	Phone:		
Street Address:	City:	State:	Zip:
DOB:	Sex:	Social Security #:	

Insurance Information

Primary Insurance Information: <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid	Secondary Insurance Information: <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid
Name:	Name:
Address:	Address:
Phone:	Phone:
Policy #:	Policy #:

SUPPORTING ICD-9 CODES / NARRATIVE DIAGNOSIS

1.	2.	3.	4.
DESCRIPTION OF ITEM		HCPCS CODE	QUANTITY

The patient named above is being treated under a comprehensive plan of care. I, the undersigned treating physician certify that the above prescribed is medically necessary for the patient. I believe that the following products are both reasonable and necessary for the overall patients well being, condition and/or rehabilitation. I certify that the patient’s medical records reflect the need for the item ordered and will be made available upon request.

Physician Name:	NPI #:		
Address:	City:	State:	Zip:
Contact:	Phone:	Fax:	
Physician Signature:	Date:		

******PLEASE FAX THIS ORDER TO 704-821-1012******
Problems faxing please call (704) 821-7777