DME REFERRAL / ORDER FORM

Date:	Name of Facility:
Referral Contact:	Phone #:

PATIENT DEMOGRAPHICS

First Name:	Last Name:	M.I.	Phone:
Street Address:	City:	State:	Zip:

DOB:	Sex: M F	Ht:	Wt:	Social Security #:

Emergency Contact / Responsible Party:	Phone:
Address:	Email Address:

INSURANCE INFORMATION

Primary Insurance: ❑ Medicare ❑ Medicaid ❑ Other	**Secondary Insurance:** ❑ Medicare ❑ Medicaid ❑ Other
Name:	Name:
Address:	Address:
Phone:	Phone:
Policy #:	Policy #:

SUPPORTING ICD-10 CODES / NARRATIVE DIAGNOSIS

1.	2.	3.	4.

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.

❑ Other	❑ Hospital Bed	❑ Adult Briefs / Underpads	❑ Bedside Commode
❑ Walker ❑ with Wheels	❑ Patient Lift	❑ Bed/Under Pads	❑ Shower Chair
❑ Rollator (walker w/wheels & seat)	❑ Trapeze Bar	❑ Wrist/Carpel Tunnel Brace	❑ Transfer Bench
❑ Manual Wheelchair	❑ Gel Overlay	❑ Ankle Brace	❑ Raised Toilet Seat
❑ Wheelchair Seat Cushion	❑ Low Airloss Mattress	❑ Back Brace	❑ Breast Pump
❑ Wheelchair Back Cushion	❑ Diabetic Shoes	❑ Knee Brace	❑ Urological Supplies
❑ Motorized Wheelchair/Powerchair	❑ Powerchair/Scooter Repairs	❑ Compression Hose	❑ Medical Alarm

Physician Name:	**NPI #:**

Street Address:	City:	State:	Zip

Contact:	Phone:	Fax:

Physicians Signature: ____ **Date:** ________________

(Please FAX to 704-821-7777 OR EMAIL TO ORDERS@MOBILITY- MORE.COM)

Questions call Mobility & More 704-821-7777