DME PRESCRIPTION FORM

Patient Name: ________________________________ **DOB**_____________

START DATE: ________ **REFILLS:** 12

DIAGNOSIS

ICD10 Codes **Description**

EQUIPMENT/SERVICES

*** **Any Combination of T codes can be billed but only up to 200 units** ***

Anything over the allowable listed below will need additional medical records and Insurance Authorization

Qty	Proc. Code and/or Item Description
200 Max	Diapers/Briefs any size (T4529, T4530, T4533, T4521, T4522, T4523, T4524, T4543)
200 Max	Pull Up any size (T4531, T4532, T4534, T4525, T4526, T4527, T4528, T4544)

Other: (product, Ref # and qty needed for coverage) : ______________________________

150 Max	Underpads (A4554)
250 Max	Wipes (A5120)
4 Pks/Bx	Gloves any size (A4927)
200 Max	Disposable Liner/Shield/Pads (T4535)

PHYSICIAN ATTESTATION:

I certify with my signature that I am the physician named below. The information contained on this Written Order is true and complete to the best of my knowledge. This patient was evaluated by me and treated for the condition as stated above. The patient's medical record accurately contains documentation to support medical need and utilization of the supplies prescribed by me. **This order for supplies is reasonable and necessary for the diagnosis and treatment of the patient's illness**. The patient and/or caregiver has been trained on the proper use of the supplies and is capable of following these instructions. A copy of this signed order will be maintained on file as part of the patient's medical record and made available to Medicaid or other Insurance for post payment review or audits.

PHYSICIAN NAME: ________________ **NPI #** __________________ **PHONE #** ______________

PHYSICIAN SIGNATURE____

PH# 877-748-1977 Ext 7 FAX# 877-748-1985 **Last update 01/16/2023**