Health Homecare
All your home medical equipment needs

DME Order Form
Fax Completed Form to: (423) 743-5090
Contact Us (423) 743-2330

Patient Information

Name: _____DOB_____Height_____Weight_____
Address: _____
City_____ State_____ Zip_____ Phone: (____) _____
Primary Insurance _____ID# _____Grp# _____
Secondary Insurance _____ID# _____Grp# _____
Diagnosis_____
Estimated Length of Need=99 months(lifetime) or: _____

Respiratory

Oxygen Equipment 02 Sat 88% or Below_____
□ E1390 02 Concentrator Freq_____LPM_____
□ E0431 Portable System w/conserving Device
Freq_____LPM_____ via Nasal Cannula
□ Titrate to Conserving Device LPM_____

Patient Assessment
□ Spot Check Oximetry
□ Overnight Oximetry
□ Environmental Assessment
□ Patient (Equipment) Assessment

Patient Education
☐ COPD ☐ CHF ☐ Diabetes

CPAP Equipment
□ E0601 CPAP @ _____cmH20 □ Auto Titratable
_____ _____/_____
Humidifier: □ Heated □ non-Heated
Mask Type: _____ Size:_____
Change settings on CPAP from _____ to _____.
BIPAP from_____ to _____.

BIPAP Equipment E0470
IPAP/EPAP_____/_____cmH20
Humidifier**:** □ Heated □ Non-Heated

Date of Face-to-Face Evaluation:
_____

Per insurance guidelines, a face to face evaluation for each piece of equipment ordered and the expected benefit from equipment is requested. Notes must be signed and dated by the physician. Beginning July 1, 2013 a NP, CNS, or PA may perform evaluation however, MD or DO must co-sign and date.

DME

□ **Wheelchair**
- □ K0003 Lightweight
- □ K0001 Standard
- □ K0195 Elevated Leg Rest
- □ E2601 Gel Cushion
- □ E2611 Back Cushion
- □ E0971 Anti Tippers

□ **Transport Chair E1038**
□ **Hoyer Lift E0630**
□ **Hospital Bed E0260**
□ **Trapeze Bar E0910**
□ **Bedside Commode E0163**
□ **Cane E0100**
□ **Quad Cane E0105**
□ **Walker E0135**
□ **Walker W/Wheels E0143**
□ **E0143 & E0156**
Walker W/Wheels & Seat(Rollator)
□ **Gel Overlay E0185**
□ **Low Air Loss Mattress E0277**
□ **Nebulizer E0570**
- □ **A7003 Nebulizer Kits**
- □ **A7014 Nebulizer Non-Disposable Filter**
- □ **A7015 Nebulizer Mask**

□ **Crutches E0114**
□ **Lift Chair E0627**
□ **Ted Hose Up to 18 Comp.**
□ **Wrist Brace L3908**
□ **Ankle Brace L1902**
□ **Back Brace LSO**
□ **Back Brace TLSO**
□ Other _____

_____ _____ _____
Ordering Physician Signature **Date** **NPI#**

Please attach a copy of the office note with the face to face evaluation