bedard
Pharmacy & Medical Supplies

Detailed Written Order

Print

Patient Information

Name: _____

DOB: _____

Height: _____

Weight: _____

Please attach Demographics/Face Sheet

Diagnosis Code **Description**

Provider Information

Name: Bedard Pharmacy & Medical Supplies

Address: 359 Minot Avenue

Phone: (207) 784-3700

Fax: **(207) 784-7992**

Length of Need: _____ months

Patient Face to Face Exam Date: _____

Chart notes indicating medical necessity for equipment orders are **REQUIRED**.

****Medicare requires that chart notes are cosigned by M.D. or D.O if ordered by P.A., N.P., or C.N.S.****

Ambulatory & Other Aids

- ☐ Walker (E0135)
- ☐ Walker with Wheels (E0143/E0149)
  - ☐ With Rollator Seat Attachment (E0156)
- ☐ Heavy Duty Walker (E0148)
- ☐ Crutches (E0114)
- ☐ Quad Cane (E0105)
  - ☐ Narrow Base OR ☐ Wide Base
- ☐ Single Point Cane (E0100)
- ☐ Bedside Commode/Extra Wide (E0163/E0168)
- ☐ Drop Arm Commode (E0165)
- ☐ Patient Lift (E0630)
- ☐ Alternating Pressure Pad w/ pump (E0181)
- ☐ Low Air Loss Mattress (E0277)
- ☐ Other:_____

Respiratory

- ☐ Nebulizer Compressor (E0570)

Beds & Wheelchairs

- ☐ Hospital Bed with Rails (E0260)
  - ☐ Standard Mattress (E0272)
  - ☐ Gel Mattress Overlay (E0185)
  - ☐ Dry Pressure Mattress (E0184)
  - ☐ Trapeze Bar
    - ☐ Attached
    - ☐ Free-standing
- ☐ Wheelchair ☐ 16 x 16 ☐ 18 x 16 ☐ 20 x 16
  - ☐ Standard/Hemi (K0001/K0002)
  - ☐ Lightweight (K0003)
  - ☐ Wide (K0006)
  - ☐ Extra Wide (K0007)
  - ☐ Foot Rests
  - ☐ Elevating Leg Rests (E0990/K0195)
  - ☐ Articulating Leg Rests (K0053)
  - ☐ Anti-Tippers (E0971)
- ☐ Wheelchair Cushion
  - ☐ Standard/Wide (E2601/E2602) ☐ Skin Protection
- ☐ Wheelchair Back
  - ☐ Standard/Wide (E2611/E2612) ☐ Skin Protection
- ☐ Other:_____

Anticipated Date of Discharge/Date Needed

_____

I, the undersigned, certify that the above prescribed equipment and/or supplies are reasonable and medically necessary as part of treatment for this patient. The need and medical necessity for the above listed equipment and/or supplies is documented in the patient's medical record and is available upon request.

Physician's Signature _____ Date _____

Credentials

Physician Name:_____ NPI Number:_____

Address:_____ Phone Number:_____

City, State, Zip:_____ Fax Number:_____

FAX TO: (207)784-7992

www.BedardPharmacy.com/referrals.shtml