bedard
Pharmacy & Medical Supplies ☑

DME Detailed Written Order

Please fax completed form to 207-784-7992

Patient Information

Name:____

DOB:_____________ Height:__________ Weight:____________

Patient Face-to-Face Exam Date:____________________________

Length of Need:_________________________________ months

Provider Information

Name: Bedard Pharmacy & Medical Supplies

Address: 359 Minot Ave, Auburn, ME 04210

Phone: 207-784-3700

Fax: 207-784-7992

Chart notes indicating medical necessity for equipment orders are REQUIRED

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

Diagnosis Information

ICD-10 Code:_____________ Description:____

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ICD-10 Code:_____________ Description:____

Ambulatory & Other Aids

- ☐ Walker (E0135)
- ☐ Walker with Wheels (E0143)
  - ☐ 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) ☐ Trapeze Bar
  - ☐ Gel Mattress Overlay (E0185) ☐ Attached
  - ☐ Dry Pressure Mattress (E0184) ☐ Free-Standing
- ☐ Wheelchair ☐ 16 x 16 ☐ 18 x 16 ☐ 20 x 16
  - ☐ Standard/Hemi (K0001/K0002) ☐ Foot Rests
  - ☐ Lightweight (K0003) ☐ Articulating Leg Rests (K0053)
  - ☐ Wide (K0006) ☐ Elevating Leg Rests (E0990/K0195)
  - ☐ Extra Wide (K0007) ☐ 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

Physican Name:__________________________________ NPI #:________________________

Address:____

Street *City* *State* *Zip*

Phone #:____________________________ Fax #:______________________________

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