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 #:_____