DME Prescription

11918 Farmington Rd
Livonia, MI 48150
Phone: (734) 522-8531
Fax: (734) 522-6846

Physician: _____
Address: _____

Beneficiary: _____
Address: _____

Insurance ID: _____
DOB: _____

THE INSURANCE COMPANY REQUIRES ALL OF THE FOLLOWING INFORMATION TO BE SUPPLIED BY THE ORDERING PHYSICIAN:

Durable Medical Equipment

Check ALL that apply

Semi-Electric Hospital Bed		Standard Wheelchair w/ Footplates	
Alternating Pressure Pad		Highback/Reclining Wheelchair with Elevated Legrests and Anti-Tippers	
Patient Lift (Manual)			
All-In-One Commode		Gel Cushion	
Nebulizer w/ Kit		Geri Chair	
		Walker w/ Wheels	

Patient Height: _____ Patient Weight: _____

Beneficiary Diagnosis **(ICD-10 REQUIRED)**: _____

Reason for DME: _____

Length of time equipment will be needed: _____

Last Face-To-Face Appointment with Physician **(within 30 days)**: _____

Initial Date This Equipment Was Prescribed: _____

Physician NPI: _____

Physician Signature (not stamped): _____

Date Signed: _____