TODAYS DME INC

1312 Redwood Ave Grants Pass OR 97527
Ph 541-787-4515 Fx 541-787-4530
melody.hannah@todaydme.com

Written Order Prior Delivery / Detailed Written Order

Patient Name: _____ Patient DOB: _____
Order Date: _____

Chart notes Attached (chart notes must include the need for equipment being ordered)
I, the undersigned, certify that the below prescribed equipment/supplies is medically necessary as part of my treatment plan for this patient. In my opinion, the equipment prescribed is reasonable and necessary for accepted standards of medical practice and treatment of this patient's condition and has not been prescribed as "convenience equipment". I have documented the following information and the need for this equipment in the patient's most recent chart notes.

DIAGNOSIS (Check appropriate diagnosis below) Length of Need: ☐ 12 months ☐ 99 months

ICD-10 Diagnosis Code(s): _____

Commode Products & Supplies are medically necessary (Check equipment/supplies ordered)

QTY	HCPC Code	Description of specific services to be provided
	E0163	COMMODE CHAIR, MOBILE OR STATIONARY, WITH FIXED ARMS
	E0165	COMMODE CHAIR, MOBILE OR STATIONARY, WITH DETACHABLE ARMS
	E0167	PAIL OR PAN FOR USE WITH COMMODE CHAIR, REPLACEMENT ONLY
	E0168	COMMODE CHAIR, EXTRA WIDE AND/OR HEAVY DUTY, STATIONARY OR MOBILE, WITH OR WITHOUT ARMS, ANY TYPE, EACH

Additional Information: A commode is covered when the beneficiary is physically incapable of utilizing regular toilet facilities. This would occur in the following situations:

	Yes	NO
1A The beneficiary is confined to a single room, or	☐	☐
1B The beneficiary is confined to one level of the home environment and there is no toilet on that level, or	☐	☐
1C The beneficiary is confined to the home and there are no toilet facilities in the home	☐	☐
2. What does the patient Weigh _____ lbs		
3. A commode chair with detachable arms (E0165) is covered if the detachable arms feature is necessary to facilitate transferring the beneficiary or if the beneficiary has a body configuration that requires extra width.	☐	☐

Prescribing Physician's Information

Name & Credentials _____ NPI# _____
Telephone _____ Fax _____
Address _____
Signature _____ Signature Date _____