TODAYS DME INC

1312 Redwood Ave
Grants Pass OR 97527

Ph 541-249-9860
Fx 541-249-9859
melody.hannah@todaydme.com

Detailed Written Order Prior to Delivery

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): _____

Patient Lift Products & accessories are medically necessary (Check equipment/supplies ordered)

QTY	HCPC Code	Description of specific services to be provided
	E0630	Patient lift, hydraulic or mechanical, includes any seat, sling, straps or pads
	E0635	Patient lift, electric with seat or sling
	E0621	Sling or seat, patient lift, canvas or nylon

Additional Information:

1) Patient needs transferred between bed and a chair, wheelchair, or commode and without the use of a lift, the patient would be bed confined	☐ YES	☐ NO
2) Does patient use a cane, crutches, or walker	☐ YES	☐ NO
3) What does the patient weight _____ lbs		
4) Does the patient's height exceed 6ft?	☐ YES	☐ NO

Prescribing Physician's Information

Name & Credentials _____ NPI# _____

Telephone _____ Fax _____

Address _____

Signature _____ Signature Date _____