dMedicus Durable Medical Equipment for Physicians

PATIENT NAME: _____ DOB: _____

POLICY HOLDER: _____ DOB: _____

INSURANCE/CLAIMS MAILING ADDRESS: _____

_____

ID#: _____ GROUP#: _____

PATIENT MAILING ADDRESS: _____

HOME PHONE: _____ CELL PHONE: _____

HEIGHT: _____ WEIGHT: _____ SEX: MALE/FEMALE

PRESCRIBED PRODUCTS

- ☐ EMS
- ☐ TENS
- ☐ GARMENT
- ☐ EMS/TENS SUPPLIES
- ☐ WHEELCHAIR
- ☐ ROLLATOR
- ☐ WALKER/CANE
- ☐ KNEE/ELBOW/BACK BRACE

OTHER 1_____ 2_____ 3_____

LENGTH NEEDED: INDEFINITE.....PURCHASE

DIAGNOSIS: _____

DIAGNOSIS CODE(S) 1_____2_____3_____4_____

MEDICAL NECESSITY

PROGRESS NOTES MUST BE SENT WITH THIS FORM TO COMPLETE YOUR ORDER

_____

PHYSICIAN NPI: _____

PHYSICIAN NAME: _____

PHYSICIAN ADDRESS: _____

PHYSICIAN SIGNATURE: _____

DATE: _____

THANK YOU FOR YOUR BUSINESS!

PLEASE FAX TO: 1-866-279-6774 OR CALL WITH QUESTIONS 469-698-0250