OLD WORLD DME INC: HOME MEDICAL EQUIPMENT ORDER FORM

YOUR LOCAL MEDICARE ADVANTAGE PLUS BLUE PPO, BCBSM, CMS, & MEDICAID APPROVED PROVIDER SINCE 2007!!!

PHONE: (248) 669-2416 FAX: (248) 671-0922 MOBILE/TEXT: (248) 763-4737 EMAIL: bcooper@oldworlddme.com

PATIENT INFORMATION:

LAST NAME: **FIRST NAME:** **DOB: / /**

STREET ADDRESS: **APT/BUILDING #:**

CITY: **STATE:** **ZIP:**

TELEPHONE ( ) - **HEIGHT: in.** **WEIGHT: lbs.**

EMERGENCY CONTACT PERSON: **TELEPHONE ( ) -**

APPLICABLE EQUIPMENT(S) DIAGNOSIS/ICD(S): #1 #2 #3 #4 #5 #6 #7

ESTIMATED DURATION OF NEED (1 to 98 Months OR 99 Months = Lifetime): MONTHS

DATE OF FACE-TO-FACE IN PATIENT'S PROGRESS NOTES (IF APPLICABLE): / /

DATE OF PATIENT'S EQUIPMENT CMN (IF APPLICABLE): / /

MEDICAL INSURANCE INFORMATION:

MEDICARE ADVANTAGE PLUS BLUE PPO ID #: *** MEDICARE ID #:**

BCBS OF MICHIGAN ID #: **MEDICAID #:**

OTHER MEDICAL INSURANCE'S ID NUMBER(S):

ORDERING PHYSICIAN'S INFORMATION:

PHYSICIAN'S NAME: **TELEPHONE ( ) -** **NPI #:**

DURABLE MEDICAL EQUIPMENT ORDER: *CMS COMPETITIVE BIDDING EFFECTED EQUIP ONLY WHERE MEDICARE IS PRIMARY

*** OXYGEN CONCENTRATOR**	*** HOSPITAL BED**	*** MANUAL WHEELCHAIR:**
*** WITH PORTABLES**	*** PRESSURE REDUCTION MATTRESS:**	*** EXTRA LIGHT**
*** LITER FLOW**	**GROUP I**	*** HEAVY DUTY**
*** HOURS PER DAY**	*** GROUP II**	*** ELEVATED LEG RESTS**
*** O2 SATURATION LEVEL %**	**PATIENT LIFT**	*** REMOVABLE ARM REST**
*** or PO2**	**TRAPEZE**	*** SEATING CUSHION**
*** TEST DATE / /**	**BEDSIDE COMMODE**	*** GEL/AIR SEAT**
*** NEBULIZER**	**DEPRESSION LIGHT THERAPY**	*** GEL/AIR BACK CUSHION**
*** CPAP**	**ERECTILE DYSFUNCTION MALE PUMP**	*** WALKER**
*** BiPAP**	**SPECIAL EQUIPMENT (SPECIFY)**	*** WALKER WITH WHEELS**
*** LEVEL**	**SPECIAL EQUIPMENT (SPECIFY)**	*** ROLLATOR**
BACK BRACE/TYPE/SIZE	**TrueBalance GLUCOSE METER**	*** POWER WHEELCHAIR**
KNEE BRACE/TYPE/SIZE	**TrueBalance TEST STRIPS**	*** ELECTRIC WHEELCHAIR**
NECK BRACE/TYPE/SIZE	**LANCETS**	*** POWER SCOOTER**
WRIST BRACE/TYPE/SIZE	**# of TESTS PER DAY**	**STRAIGHT CANE**
HAND BRACE/TYPE/SIZE	**INSULIN INJECTIONS: YES or NO**	**QUAD CANE**

PHYSICIAN'S SIGNATURE: **DATE: / /**

NOTE: Physician's Signature or Any Other CMS Approved Physician's Representative Signature is Needed to Fill Equipment Order Immediately! FAX TO (248) 671-0922 FOR DELIVERY WITHIN 24 HOURS! THANK YOU!

REVISION: 10/31/2013