Certificate of Medical Necessity/DME order

Member Name: ______________________________ DOB: ____/______/________

Address: ____________________________________ CIN: _____________________

City: ______________________ Ca. Zip: _________________

PH: _ (______) _______-__________________

Equipment Prescribed:

____ Semi- Electric Hospital bed

____ Trapeze, bed attached

____ Patient Lift

____ Low air loss mattress

____ Alternating Pressure Pad & Pump

____ Front-wheeled walker

____ Standard Wheelchair with footrests

____ Standard Wheelchair with elevating leg rests

____ Transport Wheelchair

____ Shower Chair

____ Tub Transfer Bench

___ Commode

____ Four-wheeled walker w/seat and brakes

____ Cane single point quad

____ Crutches

____ Other: ____

Length of need (# of months): ______

Diagnosis(s) (ICD-10): ____________________________ ____

Notes: ____

_______________________________________ _____/______/________

MD Signature Date

MD Name: _____________________________________ NPI: _______________________

Phone #: ____