Phone: 800-824-1400
Fax: 877-824-1411

Medical Service Company

DME Fax Order Form

Please provide DEMOGRAPHIC and INSURANCE information.

Patient Name: _____ Date Prescribed: _____/_____/_____

Address: _____ Insurance: _____

City/Zip: _____ Diagnosis: _____

Home Phone/Cell#: _____ Gender:_____ Length of need: _____99_____

Height: _____Weight: _____ D.O.B:_____

All services require a method of payment (Credit Card, Bank Information) in addition to Insurance information prior to delivery.

MSC EMPLOYEE USE ONLY ☐ CC secured

☐ Asthma (493) ☐ Bronchiectasis (494) ☐ Hypoxemia (799.02)
Chronic Obstructive: ☐ Bronchitis (491.2) ☐ Asthma (493.2)
☐ CHF (428.0) ☐ COPD (496) ☐ Emphysema (492) ☐ OSA (327.23)
☐ CSA (327.21) ☐ CVA (436) ☐ Abnormality of gait (781.2)

DURABLE MEDICAL EQUIPMENT-Height & Weight Required for ALL items on this form.

Ambulatory Devices ☐ Cane ☐ Crutches ☐ Quad cane
☐ Walker (up to 300 lbs) ☐ wheels ☐ 3 inches ☐ 5 inches ☐ fixed ☐ swivel ☐ leg extensions
☐ Extra Wide Walker 300-450 lbs ☐ Heavy Duty Walker (>350 lbs) ☐ with wheels ☐ without wheels
☐ Rollator with seat and wheels ☐ Junior Walker ☐ with wheels

Wheelchairs (up to 250 lbs) ☐ Standard ☐ Hemi (low seat) ☐ Light Weight ☐ Transport (<300 lbs) ☐ Geri Chair
☐ Heavy Duty Wheelchair (250-300 lbs) ☐ Extra Heavy Duty Wheelchair (>300 lbs) ☐ Heavy Duty Transport Chair (>300 lbs)

Wheelchair Accessories ☐ brake extensions ☐ elevating leg rests ☐ seat cushion ☐ back cushion ☐ anti-tippers ☐ seat belts
☐ Oxygen tank holder ☐ extra-wide seat (22" or more) ☐ transfer board

Beds ☐ Semi-Electric Hospital Bed ☐ Heavy Duty Full Electric (350 to 600 lbs)
☐ Extra Heavy Duty Full Electric (more than 600 lbs)

Bed Accessories ☐ Rails Half ☐ Rails Full ☐ Trapeze ☐ Free Standing Trapeze ☐ Heavy Duty Trapeze (> 250 lbs)
☐ Replacement Mattress ☐ Perimeter Mattress
☐ Patient/Hoyer Lift (maximum capacity 450 lbs) Sling ☐ full body ☐ standard ☐ Commode opening

Support Surfaces ☐ Gel Foam Overlay ☐ High Density Foam Mattress ☐ Alternating pressure ☐ Low Air Loss System

Aids to Daily Living ☐ Bedside Commode ☐ Drop Arm Commode ☐ Heavy Duty Commode (> 300 lbs)
☐ Raised Toilet Seat (max wt. capacity 250 lbs) ☐ Heavy Duty Raised Toilet Seat (up to 300 lbs)
☐ Shower Chair ☐ back ☐ no back ☐ Tub Transfer Bench
☐ Other DME:_____

ENTERAL/TUBE FEEDING (including feeding kits & all related supplies)

Formula: _____Flush: _____
☐ **Bolus/**Syringe ☐ **Gravity** w/IV Pole : _____
☐ **Pump** w/IV Pole, rate: _____

Medicare has implemented the requirement for patient Face to Face (F2F) visit prior to dispensing DME. Suppliers are required to obtain chart notes from the visit AND obtain a written order PRIOR to delivery that consists of the item AND:
1) Patient Name 2) Date Prescribed 3)Physician Signature 4) NPI

Physician's Signature: _____ Date: _____/_____/_____

Physician's Printed Name: _____ Ph: _____ Fax : _____

Address: _____ NPI: _____

Name of person filling out the form:_____ Would you like a phone call to verify receipt of fax: Yes No

Live Customer Service Hours: Monday -Friday, 8:30 am to 8 pm Saturday 9 am to 5 pm 24-hour Emergency Service Available
www.medicalserviceco.com