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**Durable Medical Equipment Order Form**

**800-403-3740**

**256-259-1498 fax**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_ Start Date: \_\_\_\_\_\_\_\_

Diagnosis(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Attach a Copy of Patient’s Demographic Page \_\_\_\_\_\_\_ Height \_\_\_\_\_\_\_ Weight \_\_\_\_\_\_\_

**Mobility (Aid Walking)**

\_\_\_\_\_ Cane (E0100) \_\_\_\_\_ Walker (E0135)

\_\_\_\_\_ Quad Cane (E0105) \_\_\_\_\_ Walker w Wheels (E0143)

\_\_\_\_\_ Rollator w/seat (E0143 & E0156) \_\_\_\_\_ Walker Heavy Duty 300lb + (E0149)

**Mobility Assistive Equipment**

\_\_\_\_\_ Wheelchair Standard (K0001) \_\_\_\_\_ Elevating Leg Rest (K0195)

\_\_\_\_\_ Wheelchair Hemi (K0002) \_\_\_\_\_ Seat Cushion (E2601)

\_\_\_\_\_ Wheelchair Lightweight (K0003) \_\_\_\_\_ Back Cushion (E2611)

\_\_\_\_\_ Wheelchair Heavy Duty (K0006) + 250 lb. \_\_\_\_\_ Other type Cushion \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ Wheelchair Extra Heavy Duty (K0007) + 300 lb. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ Safety Belt (E0978)

\_\_\_\_\_ Anti-Tippers (E0971)

\_\_\_\_\_ Heel Loops (E0951)

\_\_\_\_\_ Wheel lock extensions (E0961)

**Bed and Related**

\_\_\_\_\_ Semi Electric Bed (E0261) with (E0184) Dry Pressure Pad Standard Length \_\_\_\_\_ Bariatric Bed (E0303) 350 to 600 lbs. \_\_\_\_\_ Gel or Gel like mattress (E0185)

\_\_\_\_\_ Bariatric Bed Heavy (E0304) 600 lbs. + \_\_\_\_\_ Alternating Pressure Pad (E0181)

\_\_\_\_\_ Low Air Loss Mattress (E0277) \_\_\_\_\_ Patient Lift w Sling (E0630)

\_\_\_\_\_ Trapeze Bar for Bed (E0910) \_\_\_\_\_ Heavy Duty Trapeze for Bed (E0912) \_\_\_\_\_ Trapeze Free Standing (E0940)

\_\_\_\_\_ Bedside Commode 3in1 (E0163) \_\_\_\_\_ Heavy Duty Commode (E0168)

Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_