DME
Medical Supply Specialist

# Durable Medical Equipment Prescription
# Medical Necessity Form

## Section 1 – PATIENT & PRESCRIBING PROVIDER INFORMATION

Patient Name: _____ Phone: _____

Address: _____ DOB: _____ SS#: _____

City: _____ State: _____ Zip: _____

Prescriber's Full Name: _____ NPI #: _____

Practice Name: _____ Phone #: _____ Fax#: _____

Address: _____ City: _____ State: _____ Zip: _____

## Section 2 – INSURANCE INFORMATION

| Primary Insurance: _____ | Secondary Insurance: _____ |
|---|---|
| Name of Insured: _____ | Name of Insured: _____ |
| Insured SSN#: _____ DOB: _____ | Insured SSN#: _____ DOB: _____ |
| Insurance Carrier Address: _____ | Insurance Carrier Address: _____ |
| City: _____ State: _____ Zip: _____ | City: _____ State: _____ Zip: _____ |
| Policy/Claim #: _____ | Policy/Claim #: _____ |
| ID#: _____ Group#: _____ | ID#: _____ Group#: _____ |
| Insurance Co Phone: _____ | Insurance Co Phone: _____ |
| Contact: _____ | Contact: _____ |
| Employer: _____ | Employer: _____ |

## Section 3 - MEDICAL SUMMARY (Must be completed by Prescribing Provider or Providers Employee ONLY)

ORDER DATE: _____ LENGTH OF NEED: _____

DESCRIPTION OF ITEMS REQUESTED: _____

ICD10 Diagnosis Codes: _____ Diagnosis (Description): _____

**Diagnosis: (check all that apply)**

- ☐ Tendinitis (specified site) _____
- ☐ Hammer Toe (specified site) _____
- ☐ Charcot Foot (specified site) _____
- ☐ Ulcer (specified site) _____
- ☐ Pes Planus ☐ Pes Planovalgus ☐ Pes Cavus
- ☐ Bone Spur ☐ Bunion ☐ Neuroma
- ☐ Hemiplegia ☐ Peroneal Tendonitis ☐ Spondyloarthopathy
- ☐ Posterior Tibial Tendonitis ☐ Lower Limb Paralysis Secondary to Stroke/Trauma

**Risk Factors: (check all that apply)**

- ☐ Diabetes ☐ Obesity ☐ Non-Union
- ☐ Arthritis ☐ Osteoporosis ☐ Smoker
- ☐ Osteomyelitis ☐ Nueropathy ☐ Osteoarthritis Ankle/ Foot
- ☐ Other: _____

**Please Read and Sign Below (Please retain a copy of this prescription):** I certify that I am the prescribing provider identified in Section 1 of this form. Any Attached statement on my letterhead has been reviewed and signed by me. I certify that the medical necessity information on this form is true, accurate, and complete to the best of my knowledge. DME Medical Supply Specialist is providing the equipment being requested for the patient. For Medicare beneficiaries this is my preliminary written order; I understand a detailed written order (CMS 847) will be required.

_____ _____

Prescribing Providers Signature (Signature and date stamps are not acceptable) Date