Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form

See instructions for completing Title XIX Home Health Durable Medical Equipment (DME)/Medical Supplies Physician Order Form. This order form cannot be accepted beyond 90 days from the date of the physician's signature. Fax completed form to RightCare Medical Management (512) 383-8703.

Section A: Requested Durable Medical Equipment and Supplies

This section was completed by (check one): □ Requesting Physician □ Supplier

Client name:	Client date of birth: / /
Client Medicaid number:	Is client under 21 years of age? YES □ NO □
Supplier name:	Supplier address:
Supplier telephone:	Supplier Fax: / Supplier TPI:
Supplier NPI:	Supplier Taxonomy: / Supplier Benefit Code:
QRP name:	QRP TPI: / QRP NPI:
Physician name:	Physician telephone: / Physician Fax:

I certify that the services being supplied under this order are consistent with the physician's determination of medical necessity and prescription. The prescribed items are appropriate and can safely be used in the client's home when used as prescribed.

DME/medical supplies provider representative signature: Date: / /

DME/medical supplies provider representative name (Typed or Printed):

Item Number	HCPCS Code	Description of DME/medical supplies	Quantity	Price	Prior authorization required?	Beyond quantity limit?[1]	Custom item?[1]
1					□ Y □ N	□ Y □ N	□ Y □ N
2					□ Y □ N	□ Y □ N	□ Y □ N
3					□ Y □ N	□ Y □ N	□ Y □ N
4					□ Y □ N	□ Y □ N	□ Y □ N

1. If "Yes," additional documentation must be provided to support determination of medical necessity.

□ Check if additional documentation is attached as outlined in the TMPPM.

Is the DME Provider Medicare certified? YES □ NO □ If yes, indicate Medicare number:

Section B: Diagnosis and Medical Need Information

This is a prescription for DME/supplies and must be filled out by the prescribing physician.

Item Number[2] (From Section A)	ICD-9	Brief Diagnosis Descriptor	Complete justification for determination of medical necessity for requested item(s)[2] (Refer to Section A, footnote 1)
	_ _ _ . _ _		
	_ _ _ . _ _		
	_ _ _ . _ _		
	_ _ _ . _ _		

2. Each item requested in Section A must have a correlating diagnosis and medical necessity justification.
Enter all *Item numbers* from the table in Section A that pertain to each diagnosis.

If applicable, include height/weight, wound stage/dimensions and functional/mobility status in table below.

Height	Weight	Wound stage/dimensions	Functionality/mobility status

***Note**: The "Date last seen" and "Duration of need" items below **must** be filled in.*

Date last seen by physician: / /

Duration of need for DME: _____ month (s) Duration of need for supplies: _____ month (s)

By signing this form, I hereby attest that the information completed in Section "A" is consistent with the determination of the client's current medical necessity and prescription. By prescribing the identified DME and/or medical supplies, I certify the prescribed items are appropriate and can safely be used in the client's home when used as prescribed.

Signature and attestation of prescribing physician: Date: / /

Signature stamps and date stamps are not acceptable

Prescribing physician's license number:

Prescribing physician's TPI: Prescribing physician's NPI:

□ Check if all of the information in Section A was complete at the time of the prescribing provider signature