Hart Medical Equipment

Please fax to: (248) 353-4260
Questions call: (888) 606-8778
Central Intake

Equipment & Supply Rx

Order Date:_____

For office use only
Account #:_____
Document Type: Physician Order

Patient Name:_____ D.O.B.:_____

Phone:_____ Sex: Height:_____ Weight:_____ Insurance#:_____

Address:_____ City:_____ State:_____Zip:_____

Oxygen

☐ Concentrator & Portables w/ Content Refills ☐ Portable Only (gas) ☐ Overnight Oximetry ☐ Conserving Device/Test to maintain O2 at 90% *or* ____

☐ Humidification LPM _____ hours/day _____ Use oxygen via: ☐ Cannula *or* ☐ Mask at _____% O2

☐ Home Fill SpO2 _____% *or* PaO2 _____ Tested on: ☐ Room Air *or* ☐ On O2 at _____LPM

Test Taken at: ☐ Rest ☐ Exercise *or* ☐ Exercise w/O2 ***Please include documentation of all three results if test was taken with exercise.***

Diagnosis:_____ Duration:_____ 1-99 mos (99=lifetime)

Please include a copy of the face-to-face visit notes and a copy of qualifying oxygen SAT results.

PAP

☐ CPAP ☐ BiPAP ☐ BiPAP ST ☐ Other:_____ ☐ New Set Up *or* ☐ Repair / Replace

☐ Heated Humidifier ☐ Cool Passover Humidifier

Settings:_____

Diagnosis:_____ Duration:_____ 1-99 mos (99=lifetime)

Supplies ☐ Full Face Mask ☐ Nasal Mask ☐ Nasal Pillow ☐ Cushion Mask Name:_____ Mask Size:_____ (1/3 mos)

☐ Reusable Filter (1/6 mos) ☐ Disp. Filter (2/ mos) ☐ Tubing (1/3 mos) ☐ Heated Tubing (1/3 mos) ☐ Chin Strap (1/6 mos) ☐ Headgear (1/6 mos)

☐ Humidifier Chamber (1/6 mos) ***Please include a copy of the face-to-face visit notes and the sleep study results.***

Nebulizer and Supplies

☐ Nebulizer Compressor ☐ Reusable Neb. Kits (1/6 mos) ***Please include a copy of chart notes for new set ups.***

☐ Disposable Neb. Kits (2/ mos) ☐ Nebulizer Mask ☐ Nebulizer Filter Diagnosis:_____ Duration:_____ (1-99 mos)

Was MDI ruled out? **Y** / **N** (If no, not covered) Medication:_____ Frequency:_____

Hospital Bed

☐ Semi Electric Hospital Bed ☐ Over Bed Table ☐ Trapeze ☐ Other:_____ Diagnosis:_____ Duration:_____ (1-99 mos)

Please include a copy of the most recent chart notes stating why the patient cannot use an ordinary bed and why their head needs to be elevated more than 30 degrees.

NOTE: Hart Medical Equipment may provide semi-electric or full electric hospital beds, and we bill according to the documentation provided & insurance guidelines.

Pressure Reducing Mattress Group 1

☐ Alternating Pressure Pad & Pump ☐ Gel Mattress ☐ Foam Mattress Diagnosis:_____ Duration:_____ (1-99 mos)

Please check all conditions that apply to this patient:

☐ 1. Completely immobile
☐ 2. Limited mobility (cannot independently make changes in position)
☐ 3. Any pressure ulcer on the trunk or pelvis
☐ 4. Impaired nutritional status
☐ 5. Fecal or urinary incontinence
☐ 6. Altered sensory perception
☐ 7. Compromised circulatory status

***NOTE**: #1, #2, or #3 must be checked. If #2 or #3 is checked, one of #s 4-7 must also be checked to qualify for a mattress.*

*Note: If none of the above applies, please attach a separate sheet documenting the **medical necessity** for the items ordered.*

Please include a copy of the most recent chart notes that justify the checked conditions.

Pressure Reducing Mattress Group 2

☐ Low Air Loss Mattress ☐ Other:_____ Diagnosis:_____ Duration:_____ (1-99 mos)

Please check all conditions that apply to this patient: *(Coverage for #3 is limited to 60 days post op.)*

☐ 1. Multiple stage II ulcers on trunk or pelvis that is non-healing while on a group 1 surface with an ulcer treatment plan that includes: ongoing assessment by healthcare provider, turning & positioning, wound care, moisture & incontinence management, and nutritional intervention.
☐ 2. Large or multiple stage III or IV ulcers on trunk or pelvis
☐ 3. Myocutaneous flap/skin graft for ulcer on trunk or pelvis within past 60 days and on group 2 or 3 support surface prior to discharge from hosp/nursing facility.

Please include a copy of the most recent chart notes that justify the checked conditions.

Physician Signature

(A signature is required on pages 1 & 2 if ordering from both.)

Physician Name:_____

NPI:_____ Phone:_____ Address:_____

Physician Signature:_____ Date:_____
(No signature/date stamps)

All information documented on this form must also be documented in the patient's medical record.

Hart Medical Equipment

Please fax to: (248) 353-4260
Questions call: (888) 606-8778
Central Intake

Equipment & Supply Rx

Order Date:_____

For office use only
Account #:_____
Document Type: Physician Order

Patient Name:_____ D.O.B.:_____

Phone:_____ Sex: Height:_____ Weight:_____ Insurance#:_____

Address:_____ City:_____ State:_____Zip:_____

Ambulation Aid

☐ Folding wheeled walker w/ seat ☐ Folding wheeled walker no seat ☐ Standard walker Diagnosis:_____ Duration:_____ (1-99 mos)

☐ Knee walker ☐ Standard cane ☐ Quad cane ☐ Crutches ☐ Other:_____

Walker accessories: ☐ Glide brakes ☐ Other:_____

Commode

☐ 3 in 1 commode ☐ Heavy duty commode, Wt:_____ Diagnosis:_____ Duration:_____ (1-99 mos)

☐ Drop arm commode - *Please explain why medically necessary*:_____

Is the patient either room confined, floor confined, or unable to access toilet facilities? ☐ **Y** / **N** ☐ *(If no, it's not a covered benefit.)*

Wheelchair

WHEELCHAIR BASE Diagnosis:_____ Duration:_____ (1-99 mos)

☐ Standard Chair ☐ Hemi Chair – lower seat ☐ Light-weight Chair; unable to self-propel standard but can lightweight ☐ Reclining Chair

☐ Heavy-duty Chair > 250 lbs or severe spasticity ☐ Extra Heavy-duty Chair > 300 lbs ☐ Other:_____

ACCESSORIES

☐ Anti Tippers ☐ Brake Extensions ☐ Elevated Leg Rest: Left / Right / Bilateral ☐ Stump Support: Left / Right / Bilateral ☐ Head Rest

☐ Seat Belt ☐ Reclining Back ☐ Oxygen Cylinder Holder ☐ Removable Desk Arms ☐ Other:_____

Please include a copy of the most recent chart notes that discuss the patient's mobility limitations in the home.

Wheelchair Cushion

☐ Standard Wheelchair Cushion - *Answer #1* ☐ Wheelchair Back Cushion - *Answer #1 & 2* ☐ Skin Protection Cushion - *Answer #1 - 4*

1. Patient has had wheelchair since:_____/_____/_____ *(If not used with medically necessary wheelchair, a cushion is not a covered benefit.)*
2. Wheelchair was obtained from:_____
3. Does the patient have Decubitus Ulcers? ☐ **Y** / **N** ☐ If no, please explain medical necessity for skin protection cushion:_____
4. Is your patient susceptible to Decubitus Ulcers? ☐ **Y** / **N** ☐
5. Duration of need:_____

Diabetic Supplies

Please include a copy of the chart notes re: patient's diabetic needs.

☐ Glucose Meter ☐ Lancing Device ☐ Control Solution ☐ Battery Diagnosis:_____ Duration:_____ (1-99 mos)

☐ CGM (Continuous Glucose Monitor) ☐ Insulin Pump

NIDDM: ☐ Test Strips (50/1mo) ☐ Lancets (100/3mos) *or* **IDDM:** ☐ Test Strips (100/1mo) ☐ Lancets (100/1mo) ☐ Other:_____

1. Is the patient insulin treated? ☐ **Y** / **N** ☐ **2.** Is the patient using an insulin pump? ☐ **Y** / **N** ☐ **3.** How often is blood to be tested? _____/day.

NOTE: Over Quantity Testing (NIDDM testing more than 1x/day, or IDDM testing more than 3x/day), please send documentation with this order that includes the patient's medical record/chart notes that indicate times testing, reason for over quantity testing, and lab results.

Other

Other Equipment: _____

Quantity:_____ Frequency:_____ Diagnosis:_____ Duration:_____ (1-99 mos)

Special Instructions: _____

Please include a copy of the most recent chart notes that justifies need for the equipment.

Physician Signature

(A signature is required on pages 1 & 2 if ordering from both.)

Physician Name:_____

NPI:_____ Phone:_____ Address:_____

Physician Signature:_____ Date:_____

(No signature/date stamps)

All information documented on this form must also be documented in the patient's medical record.