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

Section A: Requested Durable Medical Equipment and Supplies

This section was completed by (check one): ☐ **Requesting Physician** ☑ **Supplier**

Client Information

Client Name:	Medicaid number:	Date of birth:

Supplier Information

Name: ONE SOURCE MEDICAL SOLUTIONS, INC.	Telephone: (214) 421-7000	Fax number: (214) 421-7001
Address: 1555 W. MOCKINGBIRD LANE, SUITE 210, DALLAS, TX 75235		

TPI:	NPI:	Taxonomy: 332B00000X	Benefit Code: DM2
QRP name:	QRP TPI:	QRP NPI:	

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):	

Prescribing Physician Information

Name:	Telephone:	Fax number:

Item Number	HCPCS Code	Description of DME/medical supplies	Quantity	Price	Prior authorization required?	Beyond quantity limit?1	Custom item?1
5					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
6					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
7					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
8					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
9					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
10					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
11					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
12					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
13					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
14					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
15					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
16					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
17					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
18					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
19					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
20					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
21					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
22					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
23					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
24					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
25					☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N

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

Section B: Diagnosis and Medical Need Information

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

By signing this form, I hereby attest that the information in Section "A", with the exception of the DME provider's signature, was complete at the time of my signature and 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 TPI:	NPI:	License number: