# PRESCRIPTION & ORDER FORM  Durable Medical Equipment Prescription

Patient Name: _____ Phone: _____

Address: _____ DOB: _____ SS#: _____

City: _____ State:_____ Zip: _____

Prescriber's Full Name: _____ NPI #: _____

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

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

## INSURANCE INFORMATION

Primary Insurance:_____

Name of Insured: _____

Insured SSN#: _____ DOB: _____

Insurance Carrier Address:_____

City: _____ State:_____ Zip:_____

Policy/Claim #: _____

ID#:_____ Group#: _____

Insurance Co Phone: _____

Contact: _____

Employer: _____

Secondary Insurance: _____

Name of Insured: _____

Insured SSN#: _____ DOB: _____

Insurance Carrier Address:_____

City: _____ State:_____ Zip:_____

Policy/Claim #: _____

ID#:_____ Group#:_____

Insurance Co Phone: _____

Contact: _____

Employer: _____

## MEDICAL SUMMARY

ICD10 Diagnosis Codes: _____ Diagnosis (Description): _____ Order Date:_____

Diagnosis: (check all that apply)
- ☐ Degenerative Disc Disease
- ☐ Internal Disc Disruption
- ☐ Herniated Nucleus Pulposus
- ☐ Pseudoarthrosis (Failed Fusion)
- ☐ Other: _____

Risk Factors: (check all that apply)
- ☐ Multi-Level Fusion ☐Obesity ☐Previous Spine Surgery
- ☐ Mixed Graft ☐Osteoporosis ☐Smoking/Nicotine
- ☐ Bone Depleting Disease ☐ Bone Depleting Medication
- ☐ Diabetes ☐ Pseudoarthrosis (Failed Fusion)
- ☐ Revision to a Failed Fusion ☐ Steroid Use ☐ Alcoholism
- ☐ Spondylolisthesis (Grade) _____

Type of Product Prescribed: _____

_____

Length of Time Needed: _____

Product Billing Code: _____

**Please Read and Sign Below (Please retain a copy of this prescription):** I am the treating physician/practitioner identified above. The information contained above is true, accurate and complete, to the best of my knowledge. Due to my diagnosis of the patient, I am ordering a bone growth stimulator. DME Medical Supply Specialist is providing a bone growth stimulator. In my medical judgment, this device is medically necessary. For Medicare beneficiaries this is my preliminary written order; I understand a detailed written order (CMS 847) will be required.

**Prescriber Signature:** _____ **Date:** _____