DME ORDER FORM

2561 W GOLF RD HOFFMAN ESTATES, IL 60169
Tel: (847) 885-8800 Fax: (847) 885-8910
www.bvmmedicalsupply.com
For Follow ups ONLY:
referral@bvmmedicalsupply.com

All Requests must be Faxed or Please use PARACHUTE

Patient Name: _____ D.O.B: _____ Tel.: ☐Cell: ☐Home: _____
EMERGENCY CONTACT: _____
ADDRESS: _____ CITY _____ STATE _____ ZIP _____
*HEIGHT: _____ *WEIGHT: _____ **REFERRAL DATE** _____
REFERRED BY: _____ **TELE NO.:** _____ **MERIDIAN MMP (C)** _____
MEDICARE NO.: _____ **MEDICAID** _____ BCBS POLICY _____

DURABLE MEDICAL EQUIPMENT

Please Include XOG

☐ WALKER W/ Front Wheels
☐ WALKER W/ NO Wheels
☐ COMPRESSION STOCKINGS ☐KNEE ☐THIGH
MEASUREMENTS: ANKLE: _____ CALF: _____ **THIGH:** _____
☐ **ROLLATOR** ☐ **HEMI WALKER**
☐ **BLOOD PRESSURE MONITOR** ☐ **NEBULIZER**
☐ **20-30 MMHG**
☐ QUAD CANE
☐ TOILET FRAME
☐ **30-40 MMHG**

☐ RAISED TOILET SEAT
☐ COMMODE
☐ HOSPITAL BED
☐ PATIENT LIFT
☐ SHOWER CHAIR
☐ WHEELCHAIR
☐ GEL OVERLAY (STAGE 1)
☐ TRAPEZE BAR
☐ TRANSFER BENCH
☐ POWERCHAIR
☐ LOW AIR LOSS MATTRESS (STAGE 2)
☐ OTHER: _____
☐ TUB RAIL
☐ SCOOTER

INCONTINENCE SUPPLIES (MONTHLY ORDER (30 DAYS))

**Wipes NOT covered

☐ **UNDERPADS 150 UNITS**
☐ **LINERS (UNISEX) 120 UNITS**
☐ **GLOVES 2 BX**
☐ **ALLERGIC TO LATEX**
☐ **PULL UPS (UNDERWEAR) 100 UNITS**
☐ **PULL UPS (UNDERWEAR) 200 UNITS**
☐ **BRIEFS (SIDE TABS) 100 UNITS**
☐ **BRIEFS (SIDE TABS) 200 UNITS**

ORTHOTICS / PROSTHETICS

☐ BACK SUPPORT
☐ KNEE BRACE
☐ DORSA-LUMBAR
☐ **WRIST BRACE**
☐ LUMBO-SACRAL
☐ SACROILIAC

☐ ANKLE BRACE MEASUREMENT: _____ SHOE SIZE: _____
☐ AFO ☐ MULTI-PODUS ☐ NIGHT SPLINT ☐ STIRRUP
☐ WALKING BOOT ☐ OTHER: _____

MISCELLANEOUS (PROVIDE REF/REORDER NUMBER)

☐ INTERMITTENT SELF CATHETER
☐ INDWELLING CATHETER (FOLEY)
☐ LEG BAG
☐ BEDSIDE DRAINAGE BAG
☐ WOUND (REQUIRES QUESTIONNAIRE) **MUST BE GREATER THAN STAGE I

LIST REFERENCE NUMBER:

DIAGNOSIS ICD 10 CODES

**Must be related to the Medical Necessity of the item.

DIAGNOSIS: _____

ORDERING PROVIDER'S INFORMATION

**If NOT complete we cannot process request

NAME: NPI:
ADDRESS CITY: STATE: ZIP:
TEL NO.: FAX NO.:
SIGNATURE _____ DATE (MANDATORY) _____