DME ORDER FORM

2561 W GOLF RD, HOFFMAN ESTATES, IL 60169
Tel: (847) 885-8800 Fax: (847) 885-8910
www.bvmmedicalsupply.com

Patient Name: _____ D.O.B: _____ Tel.: ☐Cell: ☐Home: _____
EMERGENCY CONTACT: _____
ADDRESS: _____ CITY _____ STATE _____ ZIP _____
*HEIGHT: _____ *WEIGHT: _____ REFERRAL DATE: _____
REFERRED BY: _____ FACILITY: _____ TEL. NO.: _____
MEDICARE NO.: _____ MEDICAID NO.: _____ OTHER(MCO): _____
ADD POLICY NUMBER^

DURABLE MEDICAL EQUIPMENT

☐ WALKER ☐ ROLLATOR ☐ CANE ☐ QUAD CANE
☐ CRUTCHES ☐ BLOOD PRESSURE MONITOR ☐ NEBULIZER ☐ TOILET FRAME
☐ COMPRESSION STOCKINGS ☐KNEE ☐THIGH ☐ WAIST ☐ 18-20 ☐ 20-30 ☐30-40 ☐ TED HOSE
MEASUREMENTS: ANKLE: CALF: WAIST:
☐ RAISED TOILET SEAT ☐ SHOWER CHAIR ☐ TRANSFER BENCH ☐ GRAB BAR
☐ COMMODE ☐ WHEELCHAIR ☐ POWERCHAIR ☐ SCOOTER
☐ HOSPITAL BED ☐ GEL OVERLAY (STAGE 1) ☐ LOW AIR LOSS MATTRESS (STAGE 2)
☐ HOYER LIFT ☐ TRAPEZE BAR ☐ OTHER: _____

INCONTINENCE *(SPECIFY IF ALLERGIC)*

☐ UNDERPADS ☐ LINERS ☐ GLOVES
☐ DIAPER ☐ PULL ON (UNDERWEAR) ☐ OTHER: _____

ORTHOTICS/ PROSTHETICS

☐ BACK SUPPORT: ☐ DORSA-LUMBAR ☐ LUMBO-SACRAL ☐ SACROILIAC
☐ KNEE BRACE MEASUREMENT: ☐ WRIST BRACE: MEASUREMENT:
4" ABOVE KNEE:_____
CENTER KNEE: _____
4" BELOW KNEE_____

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

ENTERAL FEEDING (ONLY FOR G-TUBE FEEDING)

☐ ENSURE ☐ GLUCERNA ☐ BOOST ☐ JEVITY
☐ TWO-CAL ☐ SYRINGE ☐ GRAVIYT BAG ☐ PUMP BAG
☐ POLE ☐ PUMP ☐ OTHER:

MISCELLANEOUS (PROVIDE REF/REORDER NUMBER)

☐ CATHETER ☐ WOUND ☐ OSTOMY ☐ OTHER
PLEASE INCLUDE ALL REFERENCE NUMBERS: _____

DIAGNOSIS (ICD 10 CODES *IF AVAILABLE)*

DIAGNOSIS: _____

I certify that the aforementioned is correct. I understand that intentional misrepresentation of diagnosis, services or medical necessity documentation hereby submitted, constitutes and may be subject to prosecution and or imposition of civil money penalties by federal government.

Doctor's Signature: _____ Date: _____ NPI # _____
Print Doctor's Name _____ Tele:_____ Fax: _____
Doctor's Address_____ City: _____ State: _____ Zip: _____