Phone Numbers: Local # 303-751-3700
Fax Numbers: Local Fax # 303-745-3101
8600 Park Meadows Dr. Suite 50 Lone Tree, CO 80124-2756

Email:hmsinc@live.com

We received a verbal order to provide medical equipment and supplies to the patient indicated below. This confirmation re-iterates the equipment and supplies ordered and the qualifying criteria received from your office. Please confirm the information below and make any necessary corrections. Please sign and date below where indicated. ***Thank you***

Prescription Request for: Beds, Crutches, Knee Scooters, Walkers & Wheel Chairs, etc.

Patient Name: ________________________________ **DOB:** ___/___/_____ **Sex:** _____ **Wt.**_____ **Ht.**__

Address: _______________________________________ **SS #:** _______/______/__________________

City: ________________ **State:** ______ **Zip:** __________ **Phone#** (_____) _______-_________________

Medicare #: ____________________________ **Medicaid #:** _____________________________________

Secondary Insurance Name & #: ____

Order Date: ___/___/_____ **Equipment HCPC Code:** __________ **Length of Need:** ___________ **Rental:** [__] **Purchase:** [__]
Up to 13 months Life time

(Letter of Medical Necessity/RX) **Reason or Reasons for Need:**

____

____

Diagnosis: ____ **ICD9 Code:** ____________

Description of Equipment Ordered: (**Please enter as much information for the product as possible**) ________________________________

____

I, the undersigned, certify that the above prescribed durable medical equipment is medically necessary as part of my treatment for this patient. In my opinion, the equipment prescribed is reasonable and necessary for accepted standards of medical practice and treatment of this patient's condition and has not been prescribed as "convenience equipment".

PHYSICIAN'S NAME: ____

NPI #: ______________________________ **Medicaid #:** ___________________________

ADDRESS: ____

CITY: ____ **STATE:** ______________________**ZIP:** ____________________

PHONE #: ____________________________ **FAX #:** _____________________________

PHYSICIANS SIGNATURE: ____ **DATE:** _______/_______/____________

I hereby certify that all information above is true and correct and part of my patient's record. The equipment ordered is reasonably and medically necessary for treatment of the above patient.