ADVANCED MEDICAL SOLUTIONS

"Your Complete Home Medical Equipment Company"

800-248-2229 OPTION 1 FAX TO: 800-552-9443

Reset Form

DETAILED WRITTEN ORDER PRIOR TO DELIVERY

Patient Name _____ DOB _____

Account Number _____ Height _____ Weight _____Order Date _____

☐ Face Sheet/Demographics/Chart Notes Attached

- Chart notes must include the need for equipment being ordered and **MUST BE ATTACHED FOR OVER QUANTITY**

☒ I, the Physician, have treated this patient for a condition that supports the need and have discussed the need for this medical equipment with the patient and caregivers. I have documented the following information and the need for this equipment in the patient's most recent chart notes. **Date of visit prior to order**: _____

*****MUST BE FILLED OUT FOR MEDICAID PATIENTS ONLY:**
Reason for Medical Necessity (other than diagnosis): _____

DIAGNOSIS

PRODUCTS

LENGTH OF NEED ☐ 12 Months ☐ Other _____ 99 = Lifetime **FREQUENCY OF USE** _____

NOTES

PRESCRIBING PHYSICIAN'S INFORMATION

Name and Credentials _____ NPI No. _____

Telephone No. _____ Fax No. _____

Signature _____ Signature Date _____

(Stamped Signature Not Accepted)