7 IMPORTANT STEPS for filling out the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form

See instructions for completing Title XIX Home Health Durable Medical Equipment (DME)/Medical Supplies Physician Order Form. This order form cannot be accepted beyond 90 days from the date of the physician’s signature.

### Section A: Requested Durable Medical Equipment and Supplies

This section was completed by (_check one_): □ Requesting Physician □ Supplier

#### Client Information

<table>
<thead>
<tr>
<th>Client Name:</th>
<th>Medicaid number:</th>
<th>Date of birth:</th>
</tr>
</thead>
</table>

#### Supplier Information

<table>
<thead>
<tr>
<th>Name:</th>
<th>Telephone:</th>
<th>Fax number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>NPI:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>QRP name:</td>
<td>QRP TPI:</td>
<td>QRP NPI:</td>
</tr>
</tbody>
</table>

I certify that the services being supplied under this order are consistent with the physician’s determination of medical necessity and prescription. The prescribed items are appropriate and can safely be used in the client’s home when used as prescribed.

DME/medical supplies provider representative signature: ___________________________ Date: __________

DME/medical supplies provider representative name (Typed or Printed):

#### Prescribing Physician Information

<table>
<thead>
<tr>
<th>Name:</th>
<th>Telephone:</th>
<th>Fax number:</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

1. Please enter the appropriate diagnosis code (DX) for the supplies needed.

   *Note: Incontinence Supplies Require: 1. Incontinence DX, and 2. DX that resulted in chronic incontinence

2. Please give a brief description of the DX for the supplies requested

3. Please give a justification for the medical necessity of the supplies requested

4. Date last seen by physician

   *Note: Must be within the past 12 months

5. Please specify the duration of need for supplies

   **Duration of need** items must be filled

   Date last seen by physician: __________

   Duration of need for supplies: __________

6. Physician Signature Required

   By signature, I certify that the information in Section “A”, with the exception of the DME provider’s signature, was complete at the time of the signature and consistent with the determination of the client’s current medical necessity and prescription. By prescribing the identified DME and/or medical supplies, I certify the prescribed items are appropriate and can safely be used in the client’s home when used as prescribed.

   Signature and attestation of prescribing physician: ___________________________ Date: __________

7. Date Required

   Signature stamps and date stamps are not acceptable.