Shield HealthCare

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

## 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**

| Client Name: | Medicaid number: | Date of birth: |
|---|---|---|

**Supplier Information**

| Name: | Telephone: | Fax number: |
|---|---|---|
| Address: | | |

| TPI: | NPI: | Taxonomy: | Benefit Code: |
|---|---|---|---|
| QRP name: | | QRP TPI: | QRP NPI: |

**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**

| Name: | Telephone: | Fax number: |
|---|---|---|

| Item Numb | ...scription of ...dical supplies | Qty. | Price | Prior author... | Beyond | Custom item?[1] |
|---|---|---|---|---|---|---|
| 1 | | | | | | N |
| 2 | | | | | | N |
| 3 | | | | | | N |
| 4 | | | | | | N |

1. If "Yes," ac... ...rovided to su... ...necessity.

**Section B: Diagn... ...eed Information**

***This is a prescription for D... ...E/supplies and must be filled out by the pre... ...physician.***

| Item Number[2] (From Section A) | Diagnosis | Brief Diagnosis Descriptor | Complete justification for d... ...mination of medical necessity for requ... ...ed item(s)[2] (Refer to Section A, footnote 1) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

2. Each item requested in Section A must have a... ...medical necessity justification.
Enter all *Item numbers* from the table in Secti... ...gnosis. A range of item numbers may be...

**If applicable**, include height/weight, wound s... ...nal/mobility status:

| **No... *Duration of need" items must be filled...* | Date last seen by physician: |
|---|---|
| Du... _____ month (s) | Duration of need for supplies: _____ month (s) |

**By sig... ...eby attest that the information in Section "A", with the exception of the DME provider's signature, was complete at the time o... ...signature and is consistent with the determination of the client's current medical necessity and prescription. By prescribing th... ...identified DME and/or medical supplies, I certify the prescribed items are appropriate and can safely be used in the client's home when... ...as prescribed.**

| Signature and attestation of prescribing physician: | Date: |
|---|---|

**Signature stamps and date stamps are no...**

| Prescribing physician TPI: | NPI: | License number: |
|---|---|---|

**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

**6** Physician Signature Required

**7** Date Required