



TOLL FREE 1-800-443-3390  
TOLL FREE FAX 1-800-952-5352

Please fax your patient's insurance and demographic information along with this form.

**HME  
E-Z SCRIPT**

- BOARDMAN**  
(330) 758-0595  
Fax (330) 726-2229
- CANTON**  
(330) 492-4300  
Fax (330) 492-7886
- CLEVELAND**  
(216) 341-7020  
Fax (216) 341-7023
- EAST LIVERPOOL**  
(330) 385-6412  
Fax (330) 385-3255
- GIRARD**  
(330) 545-6700  
Fax (330) 545-5555
- SHARON**  
(724) 962-5670  
Fax (724) 962-5673
- WARREN**  
(330) 395-7252  
Fax (330) 373-1190

Date: \_\_\_\_\_  
Patient Name: \_\_\_\_\_  
Patient Phone #: \_\_\_\_\_  
Address: \_\_\_\_\_  
Diagnosis/Diagnosis Code: \_\_\_\_\_

OrderedBy: \_\_\_\_\_  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
DurationofNeed: \_\_\_\_\_

**AIDS TO DAILY LIVING**

- Walker
- Wheeled Walker
- Hemi Walker
- Extra Wide Walker
- Walker Platform Attachment
- Wheeled Walker w/Seat

- Cane
- Sidestepper
- Sm. Base Quad Cane
- Lg. Base Quad Cane
- Offset Cane
- Straight Cane
- Crutches
- Crutch Platform Attachment

- Extra Wide Commode
- Drop Arm Commode
- Bedside Commode
- Confined to a single room or to one level of their home environment with no bathroom facilities.
- Bed/Chair Confined
- No indoor bathroom facilities.

**HOSPITAL BED**

- Manual Hospital Bed
- Fixed Height Hospital Bed
- Semi-electric Hospital Bed
- Variable Height Hospital Bed
- Full-electric Hospital Bed
- Half Rails
- Full Rails

- Accessories:**
- Bed-mount Traction
  - Trapeze:
  - Patient Lift
  - Bed-mount
  - Free-standing
  - Alternating Pressure Pad & Pump (APP)
  - Soft Care
  - Gel Overlay

- Condition Expected to last up to 1 month and patient requires aid positioning
- Bed required to alleviate pain.
- Requires bed lowered to transfer bed to chair/stand.
- Condition requires HOB elevation up to 30 ° (CHF, COPD, Aspiration).
- Device needed to assist to sitting to sitting position for changes in position, or getting in or out of bed.

**INCONTINENCE SUPPLIES**

- Urinary Incontinence
  - Bowel Incontinence
- Also list DX causing incontinence \_\_\_\_\_

Please indicate supplies requested: \_\_\_\_\_

**WHEELCHAIR**

- Type & Weight Limit:**
- Standard W/C (up to 250 lbs.)
  - Lightweight W/C (under 250 lbs.)
  - Heavy Duty W/C (over 250 lbs.)
  - X-tra Heavy Duty W/C (over 300 lbs.)
  - Seat Cushion
  - Back Cushion

**Size: (Seat Width)**  Child  16  18  20  22  24

- Hemi Height 17 3/4"
- Super Hemi Height under 17"
- Tall Seat over 21"
- Other: \_\_\_\_\_
- Tall Back
- Reclining Back
- Quick Release Axle
- Elevating Legrest
- Footrests
- w/Heel Loops
- Brake Extensions
- Anti-tippers (pair)
- Pelvic Strap
- Stump Support
- Amputee Set Back (Bi-Lateral AKA)

- Condition confines client to bed or chair & required to move about in residence.
- Is patient using any other ambulatory aid?  Yes  No If yes, please list other ambulatory aid: \_\_\_\_\_

**TRANSPORT WHEELCHAIR**

- Wheelchair required for use **inside** of home.
  - Heavy Duty Transport Wheelchair - Gemco (over 300 lbs.)
  - Standard Transport Wheelchair (up to 250 lbs.)
- Size:**  17  19

I certify that the medical necessity information above is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Printed Name: \_\_\_\_\_ Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ UPIN #: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_