BOARDMAN•MEDICAL•SUPPLY
BMS
COMPANY, INC.
YOUR CHOICE . . . OUR PROMISE

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WARREN
(330) 395-7252
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HME E-Z SCRIPT

****Please fax your patient's insurance information, demographics and chart notes with this form.****

Start Date: _____ Acct #:_____

Patient Name: _____ DOB:_____

Patient Phone #: _____ Ordered By: _____

Address:_____ Height: _____ Weight: _____

Diagnosis/Diagnosis Code:_____ Duration of Need:_____

AIDS TO DAILY LIVING

- ❑ Walker E0135
- ❑ Hemi Walker E0135
- ❑ Walker Platform Attachment E0154
- ❑ Wheeled Walker w/Seat E0143-E0156
- ❑ Wheeled Walker E0143
- ❑ Extra Wide Walker E0148
- ❑ Cane E0100
- ❑ Sidestepper E0135
- ❑ Sm. Base Quad Cane E0105
- ❑ Lg. Base Quad Cane E0105
- ❑ Offset Cane E0100
- ❑ Straight Cane E0100
- ❑ Crutches E0114
- ❑ Crutch Platform Attachment E0153

COMMODES

- ❑ Extra Wide Commode E0168
- ❑ Drop Arm Commode E0165
- ❑ Bedside Commode E0163

Must have one of the following reasons to be covered by insurance:

- ❑ *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

Accessories:

- ❑Trapeze E0910/Free-standing E0940
- ❑Patient Lift E0630

- ❑ Fixed height hospital bed w/ mattress w/ 1/2 rails E0250
- ❑ Fixed height hospital bed w/o mattress w/ 1/2 rails E0251

- ❑ Semi Elec Hosp Bed w/ Mattress E0260
- ❑ Semi Elec Hosp Bed w/o Mattress E0261
- ❑ Full Elec Hosp Bed w/ Mattress E0265
- ❑ Full Elec Hosp Bed w/o Mattress E0266
- ❑ Variable Height Hosp Bed w/ Mattress E0255
- ❑ Variable Height Hosp Bed w/o Mattress E0256
- ❑ Heavy Duty Hosp Bed w/ Mattress E0303
- ❑ Heavy Duty Hosp Bed w/o Mattress E0301
- ❑ Extra Heavy Duty Hosp Bed w/ Mattress E0304
- ❑ Extra Heavy Duty Hosp Bed w/o Mattress E0302

- ❑Condition Expected to last up to 1 month and patient requires aid in 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 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.) K0001
- ❑ Hemi Height W/C K0002
- ❑ Lightweight W/C (under 300 lbs.) K0003
- ❑ X-tra Heavy Duty W/C (over 300 lbs.) K0007
- ❑ Seat Cushion E2601,E2602,E2603
- ❑ Back Cushion E2611

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

- ❑ Elevating Legrest K0195/E0990
- ❑ Reclining Back E1226
- ❑ Tall Seat over 21" K0056
- ❑ Quick Release Axle K0108
- ❑ Brake Extensions E0961
- ❑ Footrests w/Heel Loops E0951
- ❑ Pelvic Strap E0978
- ❑ Stump Support E1020
- ❑ Anti-tippers (pair) E0971
- ❑ Super Hemi Height under 17" K0056
- ❑ Amputee Set Back (Bi-Lateral AKA) E0959
- ❑ Other: _____

❑ *Condition confines client to bed or chair & wheelchair 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.

Size: ❑ 17 ❑ 19 ❑ Standard Transport Wheelchair (up to 250 lbs.) E0138

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: _____ NPI #: _____ City/State/Zip: _____

Revised: 4-26-16