WWW.BOARDMANMEDICALSUPPLY.COM

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: (Date goes here)
Patient Name: (Patient's Name goes here)
Patient Phone #: (Patient Phone Number goes here)
Address: (Patient Address Goes Here - Street, City - Zip)
Diagnosis/Diagnosis Code: (Specific to required equipment)

OrderedBy: (Physician Name)
Height: (Pt. height) Weight: (Pt. weight)
DurationofNeed: (specify days/months)

(Check any applicable equipment or supply)

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

Accessories: ❑Bed-mount Traction
❑Trapeze: ❑Bed-mount ❑Free-standing
❑Patient Lift

❑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 Also list DX causing incontinence ______________
❑ Bowel Incontinence

Please indicate supplies requested: ______________________________

❑ WHEELCHAIR

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

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

❑ Hemi Height 17¾"
❑ 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.
Size: ❑ 17 ❑ 19

❑ Heavy Duty Transport Wheelchair - Gemco (over 300 lbs.)
❑ Standard Transport Wheelchair (up to 250 lbs.)

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: (Physician Signature goes here)
Printed Name: (Print Physician Name)
Phone: (Office Phone) UPIN #: (enter UPIN here)

DATE: Mo / Day / Yr
Address: (Physician Street Address goes here)
City/State/Zip: (Physician City/ST/Zip goes here)

Revised: 8-26-11