BOARDMAN•MEDICAL•SUPPLY
B M S
COMPANY, INC.
YOUR CHOICE . . . OUR PROMISE

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WARREN
(330) 395-7252
Fax (330) 373-1190
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NURSING 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:_____

❑ TENS E0730

❑ Replacement Wires A4557 1 per year

❑ TENS Kit A4595 Electrodes, Batteries, Lotion, Skin Prep, Conductive Paste/Gel, Adhesive Remover 2 kits per mo.

❑ PHOTOTHERAPY E0202

❑ Bili Level: _____

❑ CPM E0935 ❑CPM Padding A9270

Date of Surgery: _____ Side of Surgery: _____ **❑Polar Care A9270**
❑*Knee*
❑*Shoulder*

Date CPM Applied in Hospital: _____ Date of Discharge from Facility: _____

Extension _____° Flexion_____° Increase by _____° daily. Hours of use_____

_____ second pause extension to flexion
At that time tighten quad

❑ Ice to _____ knee after each session

Notes: _____

_____

_____

_____

_____

❑ SUCTION PUMP E0600 ❑ Gomco Pump E2000

❑ Suction Tubing A7002 2 per mo. ❑ Suction Catheters_____size A4624 ❑ Oral 3/week ❑ Trach 3/day
❑ Suction Yankauers A4628 3 per week ❑ Suction Filters A9900 ❑ 10 ml saline A4216 3 units per day
❑ Disposable Canister A7000 1 per mo. ❑ Closed suction system A4605 4 per month

❑ LYMPHEDEMA PUMP E0651

❑ Leg Sleeve E0667 1 every 5 years ❑ Left ❑ Right ❑ Bilateral
❑ Arm Sleeve E0668 1 every 5 years ❑ Left ❑ Right ❑ Bilateral

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