

M.R.S. HOMECARE, INC.

Written order

M.R.S. of _____

Date of Service: _____

Phone #: _____

Name: _____

DOB: _____

Address: _____

Phone #: _____

City, State and Zip: _____

Male: _____ Female: _____

Diagnosis (ICD.9): _____

Auth #: _____

Ins. Information: Co. Name: _____

Policy #: _____

Company Address: _____

Phone #: _____

Date Last Seen: _____ Length of Need: _____

Height: _____ Weight: _____

HOSPITAL BED

- _____ Semi Electric (E0260)
- _____ Trapeze Bar (E0910/E0940)
- _____ Patient Lift (E0630)
- _____ Group I Decubitus Prevention (limited mobility)
- _____ APP (E0181) documentation required
- _____ Gel Overlay (E0185) documentation required
- _____ Geo Mattress (E0184) documentation required
- _____ Group II Decubitus Prevention (multiple stage 2 or worse)
- _____ Low Air Loss (E0277) documentation required

WALKING AIDS

- _____ Cane (E0100)
- _____ Quad Cane (E0105)
- _____ Crutches: Forearm (E0111)
- _____ Underarm (E0114)
- _____ Walker: Folding (E0135)
- _____ Wheeled (E0143)
- _____ Walker Seat (E0156)
- _____ Heavy Duty (over 300) (E0148)

COMMODE (Must be room confined)

- _____ Bedside (E0163)
- _____ Drop Arm Bedside (E0165)
- _____ Extra Wide (over 300 lbs) (E0168)

OXYGEN (CMN required)

- _____ Concentrator (E1390)
- _____ Portable (E0431)
- _____ Liquid Stationary (E0439)
- _____ Liquid Portable (E0434)
- _____ Oxygen Conserver
- _____ Lpm nasal cannula

Test Study: Date performed: _____

ABG's _____

Oxygen saturation _____%

Address performed: _____

BLOOD GLUCOSE (Tested _____ times per day/7 days a week)

- _____ Monitor (E0607)
- _____ Strips (A4253)
- _____ Lancets (A4259)

INTERNAL FEEDING

Nutrition _____ Pump _____ Gravity _____ Syringe
_____ cc/hr _____ calories/day

WHEELCHAIR

- _____ Power Wheelchair (documentation required)
- _____ POV/Scooter (documentation required)
- _____ Standard (K0001)
- _____ Lightweight (K0003)
- _____ High Strength Lightweight (K0004)
- _____ Heavy Duty (over 250 lbs) (K0006)
- _____ X-Heavy Duty (over 300 lbs)(K0007)
- _____ Reclining Back (E1226)
- _____ Elevating Leg Rest (K0195)

WHEELCHAIR CUSHION

- _____ Seat: General Use (E2601/E2602)
- _____ Skin Protection (E2603/E2604)
- _____ Jay J2, Roho, etc (K0734-K0737)
- _____ Back: General Use (E2611/E2612)

NEBULIZER BID_TID_OID_Q4_PRN_

- _____ (E0570) _____ Kits (A7003/A7005)

SLEEP APNEA DEVICES

- _____ CPAP (E0601) _____ cmH2O
- _____ Bi Pap (E0470) _____ IPAP _____ EPAP
- _____ Humidification: Heated (E0562)
- _____ Non-Heated (E0561)
- _____ Supplies: mask (A7034/A7030) headgear (A7035)
- _____ chinstrap (A7036) tubing (A7037)
- _____ filters (A7038/A7039) seals (A7032)

Test Results: AHI: _____

Date performed: _____

SUCTION MACHINE

- _____ (E0600)
- _____ Catheters (A4628/A4624)

OTHER EQUIPMENT/SUPPLIES NEEDED

- _____
- _____
- _____

Physician's Signature: _____ Date: _____

NPI Number: _____