RELIABLE
MEDICAL EQUIPMENT

Phone : (630) 929-0745 Fax to Fax : (630) 929-0745
*Please include patient chart notes, demographic sheet, insurance info

Order Date : _____

DME REQUEST FORM

PATIENT INFORMATION

Name : Address :

Date of birth :

Phone Number : Gender : Weight : Height :

The following is attached :

☐ Patient's demographic sheet* ☐ Chart Notes* (within the past 120 days, signed by the MD)

COVERAGE DETAILS

Insurance Company :

Policy Number : Group Number :

EQUIPMENT REQUEST

☐ Manual Wheelchair ☐ Rollator ☐ Walker ☐ Quad Cane ☐ Crutches
☐ Power Wheelchair ☐ Dexcom ☐ Hoyer Lift ☐ Commode ☐ Scooters
☐ Blood Glucose Monitor ☐ Back Brace ☐ Knee Brace ☐ Bed pans ☐ Catheters
☐ Other : _____

QUALIFICATION

☐ E11.9 - DM wo cmp nt st uncntr	☐ I48.91 - Atrial Fibrillation	☐ R26.2 - Difficulty in walking
☐ E78.5 - Hyperlipidemia NEC/NOS	☐ I67.89 - CVA	☐ M48.00 - Spinal Stenosis
☐ E66.01 - Morbid Obesity	☐ I73.9 - Peripheral Vascular Disease NOS	☐ M54.5 - Lumbago
☐ D64.9 - Anemia NOS	☐ J44.9 - COPD	☐ M54.9 - Backache NOS
☐ F03.90 - Unspecified Dementia wo behav dis	☐ L89.159 - Pressure Ulcer, lower back	☐ R09.02 - Hypoxemia
☐ G30.9 - Alzheimer's Disease	☐ L89.209 - Pressure Ulcer Hip	☐ M62.81 - Muscle Weakness
☐ G20 - Parkinson's	☐ L89.309 - Pressure Ulcer Buttocks	☐ R60.9 - Edema
☐ G35 - Multiple Sclerosis	☐ M06.9 - Rheumatoid Arthritis	☐ R06.02 - Shortness of Breath
☐ _____	☐ _____	☐ _____

PROVIDER INFORMATION

Physician's Name : NPI :

Address :

Phone Number : Fax Number :

Physician Signature : _____ **Date :** _____