D.19 Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form

See instructions for completing Title XIX Home Health Services DME/Medical Supplies Physician Order Form.
This order form cannot be accepted beyond 90 days from the date of the physician's signature.

Section A—This section may be filled out by the DME/medical supplies provider or the prescribing physician.

Client Name: _____Medicaid Number: _____Date of Birth: _____

Name of Supplier/Vendor: _____Medicaid TPI:_____

Address of Supplier/Vendor:

Vendor Phone Number: _____Vendor Fax Number: _____

Typed or printed name of DME/medical supplies provider representative:
I certify that the services being supplied under this order are consistent with the physician's medical necessity determination and prescription.
Signature of DME/medical supplies provider representative: _____ Date:_____

TMHP USE ONLY

HCPCS Code	Description of Requested DME/Medical Supplies	Quantity	Price	Approve	Deny	Comment

Additional information or requested services may be added to the addendum page.
Addendum page attached: ❒ YES ❒ NO

Section B—This section must be filled out by the physician prescribing the DME/supplies.

Description of DME/Medical Supplies Prescribed	Quantity	Customized
		❒ Yes ❒ No
		❒ Yes ❒ No
		❒ Yes ❒ No

Diagnoses and medical necessity justification for DME/supplies:

Include height, weight, wound stage/dimensions, and functional/mobility status if applicable.

Duration of need for supplies: _____ Duration of need for DME: _____ Date last seen by physician: _____

Check all appropriate boxes.
By prescribing the identified DME and/or medical supplies, I certify to the following:

❒ The prescribed items are appropriate and can safely be used in the client's home when used as prescribed.
❒ The client is under age 21.
❒ The client is age 21 or older.

TMHP USE ONLY

Typed or printed name of prescribing physician: _____

Signature of prescribing physician: _____Date: _____
Physician signature stamps and date stamps are not acceptable.

Prescribing physician's license number: _____ Phone: _____ Fax: _____

D.20 Addendum to Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form

Section A—This section may be filled out by the DME/medical supplies provider or the prescribing physician.

Client name: _____ Medicaid Number:_____

Name of supplier/vendor: _____ TPI: _____

Typed or printed name of DME/medical supplies provider representative:_____
I certify that the services being supplied under this order are consistent with the physician's medical necessity determination and prescription.
Signature of DME/medical supplies provider representative: _____ Date:_____

TMHP USE ONLY

HCPCS Code	*Description Of Requested DME/Medical Supply*	*Quantity*	*Price*	*Approve*	*Deny*	*Comment*

Section B—This section must be filled out by the physician prescribing the DME/supplies.

Description of DME/Medical Supplies Prescribed	Quantity	Customized
		❒ Yes ❒ No
		❒ Yes ❒ No
		❒ Yes ❒ No
		❒ Yes ❒ No
		❒ Yes ❒ No
		❒ Yes ❒ No
		❒ Yes ❒ No
		❒ Yes ❒ No

Typed or printed name of prescribing physician:_____

Signature of prescribing physician: _____Date:_____
Physician signature and date stamps are not acceptable.

Prescribing physician's license number: _____