ADVANCED
Home Medical, Inc.
1-800-230-4761

312 Paseo Tesoro ♣ Walnut, CA 91789
www.advancedhomemed.com

DOCTOR'S ORDER FORM (Rx)

Ship to: ❑ Home ❑ Facility/Clinic

PATIENT

PATIENT NAME:		DOB:
SOCIAL SECURITY#:	PHONE:	
ADDRESS:		APT#:
CITY:	STATE:	ZIP:
PARENT'S NAME (if patient is minor):	PATENT'S SOCIAL SECURITY #:	

Dx / ICD-10

_____

_____

INSURANCE

INSURANCE COMPANY NAME (attach copy):	
ID NUMBER:	GROUP NUMBER:
PHONE:	FAX:

REFERRAL

CLINIC / FACILITY NAME:	
CONTACT NAME:	
PHONE:	FAX:

PHYSICIAN

Name_____

ClinicName_____
Address_____
City_____State_____Zip_____
Contact/Phone:_____

This form must be **SIGNED & DATED** by the prescribing Physician before the equipment may be dispensed.

_____ _____
Physician's Signature Date

Physician's signature certifies that the above represents his/her judgment of the patient's need for the equipment and/or supplies

HOME MEDICAL EQUIPMENT

❑ Blood pressure machine, auto (A4670)
❑ Nebulizer (E0570, A7005)
❑ Rollator, wheeled walker (E0143, E0156)
❑ Wheelchair, lightweight manual (K0003)

❑ Other specify):_____

Length of need (1-99) _____ months.

Pt Ht: _____ Pt Wt: _____

INCONTINENCE SUPPLIES

Style / Type:

❑ Disposable adult diapers. Waist:_____ inches. Avg. daily usage:_____

❑ Disposable pull-ups. Waist:_____ inches. Avg. daily usage:_____

❑ Diposable bed liners, 30 X 30 (Chux); avg. daily usage:_____

❑ Disposable gloves, non-sterile

❑ Disposable pads; Average daily use:_____

❑ Other:_____ ❑ Length of need (1-99) _____ months.

ORTHOTICS (PRE-FABRICATED)

❑ Back support belt (L0625) Waist Size (inches): _____

❑ Wrist splint, universal size (L3908) Circle: L R

❑ Knee Brace (L1812) Size (Knee Circumference): _____ inches

❑ Other specify):_____

ASSIGNMENT OF BENEFITS: The undersigned hereby authorizes Advanced Home Medical, Inc. to request on my/our behalf and to collect directly all public and private insurance benefits due to products supplied patient by Advanced Home Medical, Inc. In the event payments for insurance benefits are made directly to any of the undersigned, the payee will endorse to Advanced Home Medical, Inc. all checks for such payment.

❑ Check this box and initial if products were already received. Initials:_____

_____ _____
Patient/Guardian Signature Date

Fax to: 1-888-518-7568