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 ATTN: _____

PATIENT INFO.

PATIENT NAME:		DOB:
PHONE:	PARENT'S NAME (IF MINOR):	
ADDRESS:		APT#:
CITY:	STATE:	ZIP:

Dx / ICD-10

_____

_____

INSURANCE (Attach Copy)

INSURANCE COMPANY NAME (attach copy):

INSURANCE I.D. NUMBER:

We welcome IL MEDICAID and all MEDICAID HMOs

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

MEDICAL EQUIPMENT

❑ Blood pressure machine, auto (A4670)
❑ Back support belt (L0621, L0641)
❑ Breast pump, electric (E0603)
❑ Commode (E0163)
❑ Manual wheelchair, LtWt w legrest (K0003NU, K0053)
❑ Nebulizer with compressor (E0570, A7005, A7015)
❑ Rollator, wheeled walker with seat (E0156, E0144)
❑ Shower Chair (E0240)
❑ Walking boot pneumatic prefab (L4360)

Height:_____ inches Weight: _____ lbs

Length of need (1-99) _____ months.

COMPRESSION HOSIERY

Style / Type	Compression	Pt Ht:_____ Wt:_____
❑ Knee	❑ 15-20 mmHg	
❑ Thigh	❑ 20-30 mmHg	☒ Ship 2 pairs
❑ Pantyhose		
❑ Maternity	Ankle (inches):_____	Calf (inches):_____

INCONTINENCE SUPPLIES

Style / Type:
❑ Disp. briefs. Waist:_____ inches. Qty:_____ units per month
❑ Disp. bed underpads; Qty:_____ units per month
❑ Disp. gloves, non-sterile BX100; Qty: _____ boxes.
❑ Disp. pull-ups. Waist: _____inches; Qty:_____ units per month

❑ Other:_____

❑ Length of need (1-99) _____ months.

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