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

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

DME Form—GenericWA, Revised: FEB 2025

PARTIAL LIST OF INSURANCES:

Apple Health (Washington Medicaid FFS),
Wellpoint, CHPW
Coordinated Care Health, Molina of Washington

MEDICAL EQUIPMENT

- ❑ Blood pressure machine (A4670)
- ❑ Breast pump, electric (E0603) EDD: _____
- ❑ Blood glucose monitor, test strips, lnct (E0607, A4253, A4259) Testing frequency: _____ per day
- ❑ Power wheelchair, standard <300 lbs (K0823NU)
- ❑ Rollator, wheeled walker w/ seat (E0144NU, E0156NU)
- ❑ Walking boot pneumatic prefab (L4361)
- ❑ Wheelchair, lightweight w/ ELR (K0003NU, K0053)

Length of need (1-99) _____ months.

ORTHOTICS / BRACES

- ❑ Abdominal binder (L0628)
- ❑ Back support belt (L0621)
- ❑ Hernia guard (L8310)
- ❑ Hip brace (L1600)
- ❑ Knee brace, hinged (L1820)
- ❑ Perineal support (L8300)
- ❑ Wrist splint (L3908)

INCONTINENCE SUPPLIES

Style / Type:

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

❑ Disp. gloves, non-sterile BX100; Qty: _____ boxes.

❑ Disp. pull-ups. Waist: _____inches; Avg daily use:_____

❑ 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