GRADY HEALTH SYSTEM
HOME HEALTH DEPARTMENT
FACE-TO-FACE DURABLE MEDICAL EQUIPMENT ORDER

PATIENT NAME:_____ AREA: _____
LAST FIRST
MRN:_____ BIRTH DATE: ____/____/_____ SSN:____/____/_____

MEDICARE NUMBER:_____ MEDICAID NUMBER:_____ PRIVATE INSURANCE POLICY NUMBER:_____

HOME ADDRESS: _____

CITY:_____ STATE:_____ ZIP:_____ PHONE:_____

SOCIAL WORKER: _____ CONTACT#_____ PHYSICIAN: _____

ADMISSION DATE:____/____/_____ REFERRAL DATE:____/____/____ DISCHARGE DATE:____/____/____

DIAGNOSIS:_____ HEIGHT:_____ WEIGHT:_____

TYPE OF EQUIPMENT NEEDED:

1) Portable Oxygen Concentrator
2) Stationary Oxygen Concentrator
3) Portable Oxygen
4) _____ LPM
5) _____ Continuous Nocturnal
6) _____ Nasal Cannula

Demand type portable oxygen system will be provided

LENGTH OF TIME NEEDED: _____ HAS PATIENT APPLIED FOR: MEDICAID?_____MEDICARE?_____
SSI?_____ CLINIC IN WHICH PATIENT IS TO BE FOLLOWED: _____

NAME OF RELATIVE NOT LIVING WITH PATIENT:_____

ADDRESS:_____ CITY: _____

STATE: _____ ZIP:_____ PHONE:_____ RELATIONSHIP: _____

IS EQUIPMENT TO BE DELIVERED TO PATIENT'S HOME? ___YES___NO IF NOT, PLEASE GIVE ADDRESS OF DELIVERY SITE:

NAME: _____ RELATIONSHIP: _____
HOME ADDRESS: _____
CITY: _____STATE:_____ ZIP: _____ PHONE: _____

PLEASE NOTE BELOW ANY INFORMATION THAT MAY HELP IN PROCESSING THIS ORDER:

_____
_____

PHYSICIAN SIGNATURE: _____ PRIINTED_____DATE:_____

PHYSICIAN NPI: _____ PIC# _____

PATIENT SIGNATURE: _____ DATE: _____ (IF DELIVERED AT FACILITY)

06-11 F2FV1
Medicare Oxygen