PROFESSIONAL MEDICAL
HOME HEALTHCARE

- ☐ MEDICARE
- ☐ MEDICAID
- ☐ BC/BS
- ☐ MEDICARE _____ Managed
- ☐ OTHER _____

TAKEN BY:_____ DATE: _____

EQUIPMENT ORDER FORM

PATIENT'S NAME: _____ **SEX:** _____ **D.O.B.:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

PHONE#: _____ **OTHER#:** _____

DIAGNOSIS: _____

_____ **WEIGHT:** _____ **HEIGHT:** _____

MEDICARE#: _____ **MEDICAID#:** _____

PRIVATE INSURANCE#: _____ **AUTHORIZATION#:** _____

INS NAME/ADDRESS: _____

INS PHONE: _____ **GROUP#:** _____ **REP NAME:** _____

	EQUIPMENT/DRUG NEEDED	E-CODE
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

PERSON PLACING ORDER: _____ **DATE CALLED IN:** _____

DOCTOR: _____ **PECOS:** _____

DR. PHONE#: _____ **FAX#:** _____ **ATTN:** _____

ADDRESS: _____

NEAREST RELATIVE: _____ **PHONE:** _____

DIRECTIONS TO HOME: _____

_____.

_____.