

DURABLE MEDICAL EQUIPMENT PRESCRIPTION

NAME: _____ DOB: _____ MEMBER # _____

ADDRESS: _____ PHONE: _____

ICD-10 Code: _____ (Required)

LENGTH OF NEED: _____ Months (Required)

Were items dispensed? YES NO

Nebulizer or
Glucose Monitoring Kit # _____

	QTY PER MONTH
AUTOMATIC BLOOD PRESSURE MONITOR KIT	

DIABETIC SUPPLIES: GUIDELINE TESTING: NON-INSULIN DEPENDENT(ONCE PER DAY)**
INSULIN DEPENDENT(THREE TIMES PER DAY)**
****PLEASE FAX CHART NOTES IF ABOVE GUIDELINE TESTING****

MEMBER IS TO TEST: _____ PER DAY INSULIN INJECTIONS: _____ PER DAY

	QTY PER MONTH		QTY PER MONTH
EVENCARE TEST STRIPS 50ea/box		PEN NEEDLES 100ea/box	
EVENCARE LANCETS 100ea/box		LANCING DEVICE	
EVENCARE GLUCOSE METER (no charge meter)		CONTROL SOLUTION	
EVENCARE STARTER KIT (meter, 10 strips with lancets)		REPLACEMENT BATTERY	
SYRINGES 100ea/box			

INCONTINENT SUPPLIES (Circle supply) QTY PER MONTH

*BRIEFS (Tape- on- style)	*PULLUPS (Underwear- style)	*PANTY LINER (ANY COMBO 200 PER MO. MAX)	
DISPOSABLE UNDERPADS (Chux) (100 PER MO)			
OR WASHABLE UNDERPADS (8 PER YR MAX)			
GLOVES (2 BOXES PER MO MAX) SM: MED: LG:			

NEBULIZER SUPPLY (Circle supply) QTY PER MONTH

NEBULIZER	NEB MASK (1ea/mo)	
SPACER	DISP. NEB CUP KIT (2ea/mo)	PEAK FLOW METER

PRESCRIBING PHYSICIAN: _____



SIGNATURE: _____ DATE: _____

PLEASE FAX YOUR PRESCRIPTION TO Advanced Health at 541-269-7147