



Prescription / Medical Supplies Order Form

Patient Name: _____ Date: ____/____/____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ DOB: ____/____/____ SSN: _____

ICD-10 Code: _____ Diagnosis: _____

Medicare #: _____

Secondary Insurance: _____ Policy #: _____

Diabetic Testing Strips

Times / Day _____ ICD-9: _____

Insulin Dependent Y / N

Ambulatory Devices

- Walker (Standard)
- Walker (with Wheels)
- Rollator (Brakes, Seat)
- Quad Cane
- Straight Cane

Manual Wheelchair

- Standard Wheelchair K0001
- Standard Hemi Chair 17-18" Seat Height K0004
- Light Weight Wheelchair K0003
- High Strength Lightweight K0004
- Heavy Duty – Exceeds 250lbs

Compression Hose

- 15-20 mm HG
- 20-30 mm HG
- 30-40 mm HG

Nebulizer

- Nebulizer
- Replacement Kit, Tubing, Mask
- Adult – Standard / Child – Standard

Accessories

- Elevated Leg Rest
- Swing-away Leg Rest
- Adjustable, Detachable Leg Rest
- Anti-tippers
- Bedside Commode
- Transfer Bench
- Transfer Board / Device
- Cushion (Pressure Ease General / Gel Cushion)
- Glide Caps, Skis
- Seat Belt

Orthopedics

- 8in Wrist Splints R/L for carpal tunnel
- Wrist Splint w/ Abducted Thumb
- Hinged Knee Brace
- Stabilizer Knee Brace
- Rib Belt
- Abdominal Binder (3 panel / 4 panel)
- Lumbar Sacral Support
- Hernia Belt
- Post-op Shoe
- Walker Boot (Short / Tall)
- Tennis Elbow Strap
- Cervical Collar
- Other: _____

Dr. Name: _____ Practice Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ NPI#: _____

Signature: _____

**** Note to Medicare Patients - Due to competitive bidding we are not allowed to supply walkers, hospital beds or power chairs at this time. We are however, able to sell these items through a cash sale.**