DME Provider

CMN Order

FAX: 866-555-5555 * Phone: 1-866-555-5556

"You be the clinician...we'll be the supplier."

Patient Name: _____ Date: _____

Name of Clinic: _____ City: _____ Phone: _____

Name of Nursing Home: _____ City: _____ Phone: _____

In order for DME Provider to process your patient's order, we need the following documentation faxed:
*copy of the **PATIENT FACE SHEET** * signed (**AOB**) (at bottom) * **ORDER SIGNED BY PHYSICIAN**

OTHER PRODUCTS & NOTES

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DRESSINGS	DRAINAGE	WOUND 1	WOUND 2	WOUND 3	WOUND 4
Enluxtra 4x4	Mod/Heavy				
Enluxtra 6x6	Mod/Heavy				
Roll Gauze-Bioguard Barrier Wrap	Any				
Conforming Barrier Wrap - BIOGUARD	Any				
Co-Lastic LF-4"	Any				
SurePress Cast Padding	Any				
Comprilan	Any				
Gauze AMD (Antimicrobial)	Any				
Hypafix	Any				
Paper Tape 2"	Any				

Patient Needs Saline: Yes No

Is this patient currently being seen by **Home Health**?

☐ Yes ☐ No

Have wounds ever been debrided?

☐ Yes ☐ No

☐ Please contact me regarding my financial responsibility

Frequency of Change				
Description				
Size & Depth (in cm's)				
Location				
Partial(PT)Full(FT)Thickness				
Drainage (Min. Mod. Heavy)				
Is This Patient Currently in a **Nursing Home**? ☐ Yes ☐ No			**Part A Bed?** ☐ Yes ☐ No	
Duration: 90 Days (Unless Spec)				

I certify that I am treating the patient identified on this form and order the listed supplies based on my examination/treatment of the patient. I affirm that the ordered supplies are medically reasonable and necessary. I have noted on the form my medical findings regarding the patient's wound(s) and medical supply needs. I am maintaining documentation regarding my medical treatment of the patient and will make it available upon request.

Physician's Name: _____ Fax: _____ Phone: _____

Signature: _____ Date: _____ UPIN: _____ NPI: _____

City: _____ State: _____

Assignment of Benefits (AOB)

I request that payment of my insurance benefits be made to DME Provider for any supplies or services furnished to me by DME Provider. I am responsible for any balance due that is not covered by my insurance. I understand any product received in my home, opened or unopened, cannot be returned. I authorize any holder of medical information about me to release to DME Provider any information needed to determine benefits payable for these supplies or services. Further, I authorize DME Provider to forward my medical records to the medical professionals in my care and/or make copies of said records.

☐ I am aware that my Patient Rights, The Complaint Process, Supplier Standards, and HIPAA Regulations will be inserted in my first box of supplies I receive from DME Provider

Patient's Name: _____ Date of Birth: _____ SSN: _____

Address: _____ Phone: _____

Patient's Signature: _____ Authorized Signature: _____ Date: _____

Name of Authorized Representative: _____ (If Patient is unable to sign)