ADVANCED
Home Medical, Inc.
1-800-230-4761

312 Paseo Tesoro ♣ Walnut, CA 91789
www.advancedhomemed.com

DOCTOR'S ORDER FORM (Rx)

Ship to: ❑ Home ❑ Facility/Clinic

PATIENT

PATIENT NAME:		DOB:
PARENT'S NAME (if patient is minor):	PHONE:	
ADDRESS:		APT#:
CITY:	STATE:	ZIP:
INSURANCE COMPANY NAME (attach copy):	POLICY NUMBER:	

Dx / ICD-10

_____

_____

INSURANCE LIST (PARTIAL)

AHPSC
Access IPA
Aetna Better CA
Angeles IPA
Anthem Blue Cross
Bella Vista
Blue Shield Promise
Brand New Day
CA Health & Wellness
CalViva
CCIPA
CalOptima
CenCal Health
CCAH
Cigna
Gold Coast Health Plan
Health Net
Health Plan of San Mateo
Hispanic Physicians IPA
IEHP
Imperial Health
LA Care
Medi-Cal FFS
Medicare FFS
Nivano
Noble IPA
Oscar Health Plan
Partnership
Prospect Medical
River City Med Grp
SFHP
Sante Health Systems
UCMG
Wellcare

PHYSICIAN

Name / NPI _____

Address_____

City _____ State _____ Zip_____

Contact/Phone:_____

This form must be **SIGNED & DATED** by the prescribing Physician before the equipment may be dispensed.

_____ _____
Physician's Signature Date

Physician's signature certifies that the above represents his/her judgment of the patient's need for the equipment and/or supplies

HOME MEDICAL EQUIPMENT

❑ Front wheel walker (E0143)
❑ Hospital Bed (E0295NU), Mattress (E0271), Rails (E0310)
❑ Low air loss mattress, daily rental (E0277)
❑ Nebulizer with compressor (E0570NU, A7005)
❑ Power wheelchair, standard <300 lbs (K0823NU)
❑ Quad cane (E0105)
❑ Rollator, wheeled walker (E0144NU, E0156NU)
❑ Wheelchair, heavy duty > 250 lbs (K0006NU, K0052NU)
❑ Wheelchair, lightweight w/ ELR (K0003NU, K0053)
❑ Wheelchair, standard w/ SLR (K0001NU, K0053)

Length of need (1-99) _____ months.

Pt Ht: _____ Pt Wt: _____

INCONTINENCE SUPPLIES

Style / Type:

❑ Disposable adult diapers. Waist:_____ inches. Avg. daily usage:_____

❑ Disposable pull-ups. Waist:_____ inches. Avg. daily usage:_____

❑ Disposable underpads, 30 X 30 (Chux); Avg. daily usage:_____

❑ Disposable gloves, non-sterile QTY: _____ boxes (BX100)

Length of need (1-99) _____ months.

ORTHOTICS (PRE-FABRICATED)

❑ Posture corrector, thoracic LSO (L0627) Waist Size (inches): _____
❑ Wrist splint, universal size (L3908) Circle: L R
❑ Knee Brace (L1820) Size (Knee Circumference): _____ inches

❑ Other specify):_____

ASSIGNMENT OF BENEFITS: The undersigned hereby authorizes Advanced Home Medical, Inc. to request on my/our behalf and to collect directly all public and private insurance benefits due to products supplied patient by Advanced Home Medical, Inc. In the event payments for insurance benefits are made directly to any of the undersigned, the payee will endorse to Advanced Home Medical, Inc. all checks for such payment.

❑ Check this box and initial if products were already received. Initials:_____

_____ _____
Patient/Guardian Signature Date

Fax to: 1-888-518-7568