CPAP • Oxygen • Mobility • Home Medical Equipment

HomeCare Equipment Order Form

Fax or Call for Orders:

5027 Harrison Ave.
Rockford, IL 61108
PHONE: 815.227.0202

2020 Sutler Ave.
Beloit, WI 53511
PHONE: 608.313.0800

FAX: 866.511.5752
www.integratedhc.com

Order Date ______________________

Patient Information

Patient Name ______________________

Address ______________________

City ______________ ST ____ ZIP __________

☐ Male ☐ Female

DOB ______________

Height ______________ Weight ____________lbs

Primary Phone # ______________________

Secondary Phone # ______________________

Diagnosis

ICD10 ______________________

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Insurance Information

Primary insurance ______________________

Policy # ______________ Group # ______________

Secondary Insurance ______________________

Policy # ______________ Group # ______________

Prescribed Medical Equipment

☐ Semi-electric hospital bed

☐ Full Rails ☐ Half Rails

☐ Standard Wheelchair

☐ Wheelchair Cushion ☐ Lumbar Back Support

☐ Walker ☐ Walker w/ Wheels

☐ Trapeze Bar ☐ Lightweight Wheelchair

☐ Elevated Leg Rests ☐ Transfer Bench

☐ Cane ☐ Quad Cane

☐ Shower Chair ☐ 4 Wheel Walker w/ Seat

☐ Shower Chair w/ back

☐ Other

Length of need: ______________

Prescriber Signature ______________________ Date ______________________

Physician Name ______________________

Address ______________________

____

NPI # ______________________

Ordering Contact Name ______________________

Ordering Office Phone ______________________

By my signature, I authorize the use of this document as a dispensing prescription. I understand that the final decision with respect to ordering this (these) item(s) for this patient is a clinical decision made by me, based on the patient's clinical needs, and that my medical records support the medical need for the item(s) prescribed.

Please Note: *Additional requests for information and/or signature may be necessary to support proper billing for item(s)*