MEDI-RENTS & SALES INC.

800-540-7252
Apnea Monitor

Referred by: Name_____
Office_____
Phone #_____

ORDER DATE____/____/_____

Physician Order/Prescription

Fax completed form with Physician's Signature and Supporting Documentation to 844-825-3613

Patient Information

Patient Name: Date of Birth: Gender M / F

Patient Phone #: Alternate Contact: Alternate Phone #:

Address: City: State: Zip Code:

Insurance & ID# Group # Social Security #:

Medicaid #: Secondary Insurance:

ORDER DELIVERY DATE____/____/_____

FUNCTIONAL LIMITATIONS_____FAMILY AND SUPPORT SYSTEM ☐ YES ☐ NO

ABILITY TO USE AND CARE FOR EQUIPMENT ☐ GOOD ☐ NEEDS HELP SUITABLE ENVIRONMENT ☐ YES ☐ NO

Products to Dispense

☐ **(1) Apnea Monitor E0619** ☐ **(15) Electrodes Kitty Cat Pre-wired A4556 (changed every three days)**

Diagnosis Information

☐ **P27.1-Bronchopulmonary dysplasia** ☐ **P22.0-Respiratory distress syndrome** ☐ **P29.12-Neonatal bradycardia**

☐ **R06.81-Apnea** ☐ **R68.13-Brue\ALTE** ☐ **R00.1-Bradycardia, unspecified** ☐ **A37.90-Whooping Cough**

☐ **J98.8 other specified respiratory disorders** ☐ **K21.9-GERD** ***secondary** ☐ **Other**_____

Date of last Bradycardia or Apneic event:_____/_____/_____ ***(must be in the clinical documentation)**

LENGTH OF NEED (# OF MONTHS): _____ 1-99 (99=LIFETIME)

Date last seen: ____/____/_____ Prognosis:_____ **Medical Justification:** _____

Physician Information

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

Address: _____ City: _____ State: _____ Zip: _____

NPI#: _____ License #: _____ Exp Date: ____/____/____ (MM / DD / YY)

Physician's Signature _____ **Date** ____/____/____ (MM / DD / YY)

By my signature above, I confirm that the patient has the medical condition(s) listed and is being treated by me. All the information contained on this Physician's Order accurately reflects the patient's medical condition(s) and the treatment regimen that I have prescribed. The medical records for this patient substantiate the prescribed treatment plan. The patient/caregiver is able to use the prescribed product(s) listed above. My office has informed the patient that this order has been submitted to a DME supplier on behalf of the patient. For Medicare, Medicaid or other insurance requirements, I will maintain this signed original document in the patient's medical record file for post-payment review/audit purposes.

medirents.net

Approved By ACHC