



Easy Order Form

Specializing in Respiratory Home Health Care and Rehab Equipment

Patient Name: _____ Phone: _____ Date Ordered: _____

Address: _____ City/State/Zip: _____

Primary Diagnosis: ICD-9 _____ Secondary Diagnosis: _____ Length of Need: _____

Social Security #: _____ DOB: _____ Ht: _____ Wt: _____

Insurance Provider: _____ Policy # _____ Group # _____

Note: We encourage you to send us the patient's demographic sheet along with this order form. Thanks for the order! -FHM staff.

Those items in Red & with a () are required by most insurance companies, to use a Certificate of Medical Necessity(CMN) or other form.

Oxygen Equipment		Sleep Therapy (Send Sleep Study)		Respiratory Products				
Overnight Oximetry		CPAP + Supplies		Nebulizer with non-disposable kit				
Oxygen Concentrator* @ _____ LPM		AUTO-CPAP + Supplies Range (_____ cm to _____ cm for _____ weeks)		Note: Patient is responsible for own meds.				
Portable Oxygen Equipment*		Bi-PAP + Supplies		Suction Machine				
Oxygen Conserver* @ _____ LPM		Bi-PAP ST + Supplies		Percussor				
Apnea Link		CPAP Supplies (Only)		Other:				
O2Sat% _____ @ _____ LPM Test Date _____ <i>Check box below on how test was performed.</i> <table border="1" style="display: inline-table;"> <tr> <td>Rm Air @ Rest</td> <td>Exercise</td> <td>Sleep</td> </tr> </table> Upon Physician's Request -Titration <input type="checkbox"/> Respiratory Therapist to Titrate O ₂ Sat. >90% Note: O ₂ Sat% at or below 88% qualifies the patient for Medicare eligibility.		Rm Air @ Rest	Exercise	Sleep	<i>Note: When ordering the above items, the below information must be filled out.</i> Heated Humidity (Yes/No) Inhalation pressure @ _____ cm Exhalation pressure @ _____ cm Backup Rate _____ (Note: Backup Rate only applies for BiPAP ST)		<input type="checkbox"/> Wellness Check <ul style="list-style-type: none"> • Patient Education • In-Home Assessment • Overnight Oximetry 	
Rm Air @ Rest	Exercise	Sleep						
Wheelchairs		Patient Room		Diabetic Supplies				
Elevating Legrests*		Hospital Bed, Semi-electric*		Lancets*				
Lightweight Style*		Trapeze		Test Strips*				
Heavy Duty, Wide*		Patient Lift		Glucometers*				
Reclining*		Over-bed Table						
Standard*		Seat Lift Chair, Electric*		Ambulatory				
Power Wheelchair*		Other:		Wheeled Walker w/Seat				
Power Scooter*				Folding Walker				
Wheelchair Evaluation		Decubitus Products		Folding Walker w/Wheels				
Other:		Low Air Loss Therapy Bed*		Heavy Duty 4-Wheeled Walker				
Bathroom Safety		Alternating Pressure Pad*		Platform for Walker				
Commodes*		Wheelchair, Gel Air Cushion*		Quad Cane				
Grab Bars		Wheelchair Custom Cushion*		Crutches				
Hydraulic Tub Lift		Wheelchair Back System*		Cane				
Toilet Risers				Quad Cane				
Toilet Safety Rail		Mobility Assistance		Other:				
Hand Held Shower		Ramps		Miscellaneous				
Bathtub Shower Chairs		Van Lifts		Blood Pressure Monitor				
Bathtub Safety Rail		Stair Glides		Compression Stockings				

Physician Signature: _____ **Date:** _____ **Sent by:** _____

Physician Name: _____ **NPI#** _____

Name of Clinic/Hospital: _____ **Phone:** _____

Address: _____ **City/State/Zip:** _____

We take all insurances!