



INNOVA MEDICAL PRODUCTS



DME Order Checklist for Referring Providers

Please fax the following information to help us process your Durable Medical Equipment (DME) order quickly and accurately. Incomplete submissions are the most common cause of processing delays.

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- ☐ **Patient demographics**
 - ☐ **Completed Rx form**, signed and dated with either a wet signature or "Electronically signed by..."
 - ☐ **Current insurance information**, with copy of front and back of insurance card
 - ☐ **Medical records dated within the last 6 months**, indicating need for the equipment
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Before You Fax

- ☐ Confirm all pages are legible and complete
- ☐ Confirm the order is signed and dated by the prescriber
- ☐ Confirm all quantities are correct
- ☐ Confirm diagnosis codes, number of refills, and length of need are on the Rx and all coverage questions have been completed
- ☐ Include a cover sheet noting the number of pages and a callback number in case we have questions

Fax to: 860-388-0368

Questions? Call us at: 860-388-1437

This checklist is a general guide. Specific documentation requirements can vary by insurance payer and equipment type — our team will follow up if anything additional is needed.



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An Innova Medical Group Company



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COMMODE PRESCRIPTION FORM

Patient Name _____ Phone _____

Address _____

Email _____

DOB _____ Height _____ Weight _____

Diagnosis codes _____ Length of Need _____

Alternate Contact Name _____ Relationship _____ Phone _____

Equipment:

- _____ E0163 Commode
_____ E0165 Drop Arm Commode
_____ E0168 Bariatric Commode

Coverage Questions:

- Y N Is there a bathroom in the home?
Y N Is the patient confined to one level of the home that has no bathroom?
Y N Is the patient confined to one room in the home?
Y N Does the patient require drop arms to facilitate transfer to commode?
Y N Does the patient weigh more than 300 lbs?

**PLEASE SUPPLY A COPY OF THE NOTES FROM THE FACE-TO-FACE VISIT
(ALL CLINICAL NOTES MUST BE EITHER ELECTRONICALLY SIGNED OR HAVE A WET SIGNATURE)**

Physician Name _____ NPI _____

Address _____

Phone _____ Fax _____

Physician Signature _____ Date _____