INNOVA MEDICAL PRODUCTS

Northeast Medical Products, Inc

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.

- ☐ **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.

Northeast Medical Products, Inc

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860-388-1437 FAX: 860-388-0368
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An Innova Medical Group Company

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COMPRESSION STOCKINGS (READY TO WEAR) PRESCRIPTION FORM

Patient Name _____ Phone _____

Address _____

Email _____

DOB _____ Height _____ Weight _____

Diagnosis Code _____ Length of Need _____

Alternate Contact Name _____ Relationship _____ Phone _____

COMPRESSION (CIRCLE ONE)			
8-15 mmHg	15-20 mmHg	20-30 mmHg	30-40 mmHg
STYLE (CIRCLE ONE)			
KNEE	THIGH	WAIST	MATERNITY
FULL FOOT		**OPEN TOE**	

Quantity (Pair) _____ Number of Refills _____

Measurements

	LEFT	RIGHT
Ankle		
Calf		
Thigh		
Length		
Hip		
Fitter Initials	**Date/Time**	

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

Physician Name _____ NPI _____

Address _____

Phone _____ Fax _____

_____ _____
Physician Signature Date