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.

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860-388-1437 FAX: 860-388-0368
www.northeastmedicalproducts.com
An Innova Medical Group Company

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GROUP I SUPPORT SURFACE PRESCRIPTION FORM

Patient Name _____ Phone _____

Address _____

Email _____

DOB _____ Height _____ Weight _____

Diagnosis codes _____ Length of Need _____

Alternate Contact Name _____ Relationship _____ Phone _____

Equipment ordered:

_____ E0181 Alternating Pressure Pad and Pump

_____ E0185 Gel or Gel Like Pressure Pad for Standard Mattress

Coverage Questions:

Y N The patient is completely immobile – i.e., patient cannot make changes in body position without assistance.

Y N The patient has limited mobility – i.e., patient cannot independently make changes in body position significant enough to alleviate pressure and at least one of conditions A-D below (Please select condition(s) below)

Y N The patient has any stage pressure ulcer on the trunk or pelvis and at least one of conditions A-D below (Please select condition(s) below)

A. Impaired nutritional status
B. Fecal or urinary incontinence
C. Altered sensory perception
D. Compromised circulatory status

RELATED CLINICAL INFORMATION (Requires Face-To-Face documentation)

A beneficiary needing a pressure reducing support surface should have a care plan which has been established by the beneficiary's treating practitioner or home care nurse, which is documented in the beneficiary's medical records, and which generally should include the following:

1. Education of the beneficiary and caregiver on the prevention and/or management of pressure ulcers
2. Regular assessment by a nurse, treating practitioner, or other licensed healthcare practitioner
3. Appropriate turning and positioning
4. Appropriate wound care (for a stage 2, 3 or 4 ulcer)
5. Appropriate management of moisture/incontinence
6. Nutritional assessment and intervention consistent with the overall plan of care

Physician Name _____ NPI _____

Address _____

Phone _____ Fax _____

_____ _____

Physician Signature Date