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

520 Boston Post Rd, Old Saybrook, CT 06475
860-388-1437 FAX: 860-388-0368
www.northeastmedicalproducts.com
An Innova Medical Group Company

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TRANSPORT CHAIR PRESCRIPTION FORM

Patient Name _____ Phone _____

Address _____

Email _____

Diagnosis codes _____ Length of Need _____

DOB _____ Ht _____ Wt _____ Start Date _____

Alternate Contact Name _____ Relationship _____ Phone _____

Equipment ordered:

____ E1038 Transport Chair

Coverage Questions for Transport Chair:

Y N Does the patient have a mobility limitation that significantly impairs his/her ability to participate in one or more mobility related activities of daily living such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home?

Y N Can the patient's mobility limitation be sufficiently resolved by the use of an appropriately fitted cane or walker?

Y N Does the patient's home provide adequate access between rooms, maneuvering space, and surfaces for use of the transport chair that is being provided?

Y N Will the use of the transport chair significantly improve the patient's ability to participate in MRADLs and the patient will use it on a regular basis in the home?

Y N Has the patient expressed an unwillingness to use the transport chair that is provided in the home?

Y N Does the patient have a caregiver who is providing 24 hour a day care, and is willing and able to provide assistance with the transport chair?

Y N Is the patient unable to use a wheelchair?

PLEASE PROVIDE A COPY OF THE CLINICAL 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