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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An Innova Medical Group Company

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U-STEP WALKER PRESCRIPTION FORM

Patient Name _____ Phone _____

Address _____

Email _____

DOB _____ Length of Need _____

Diagnosis & ICD10 Code(s) _____

Alternate Contact Name _____ Relationship _____ Phone _____

Please answer the following questions to determine medical necessity for insurance coverage

Yes/No Does the patient have a severe walking problem that places him/her at heightened risk of morbidity or mortality without a walking-aid?

Yes/No Will a cane or crutch be sufficient in preventing your patient from falling and injuring himself/herself?

Yes/No Will a standard walker be sufficient for preventing your patient from falling and injuring himself/herself?

Yes/No Are you prescribing the U-Step 2 Walking Stabilizer because your patient has a severe neurological condition or limited use of a hand, and requires this product to safely ambulate and prevent serious injury due to risk of falling?

Yes/No Will your patient's mobility deficit be sufficiently resolved by using a U-Step 2?

What products are you prescribing for your patient?

- ☐ E0147 – U-Step Walking Stabilizer (DMERC MODEL #US-PC-2)
- ☐ E0156 – Accessory Seat for walker
- ☐ E0154 – Platform Attachments for walker
- ☐ Cueing Module (Laser and Auditory Cue for Parkinson's freezing)

Physician Printed Name _____ NPI _____

Phone _____ Fax _____

Physician Address _____ City, State _____

By signing below, I authorize the use of this document as a legal prescription, and I certify that the above prescribed equipment is medically necessary, reasonable, accurate and complete and is not being prescribed for convenience. I will maintain an original signed copy of this order in my medical records and make it available to Medicare, their authorized agents or other insurer, if required.

_____ _____

Physician Signature Date