DELTADRUGS

DME-Support

437 Fernando Court • Glendale, CA 91204 • **MAIN:** 800.700.6401 • **FAX:** 866.700.6401 • info@deltadrugs.com

RESET FORM

PATIENT INFORMATION

Patient Name: _____ Patient SSN#: _____

Address: _____
Address, City, State, Zip Code

Phone #: _____ 2nd Phone #: _____ Date of Birth: _____ Gender: ❑ Male ❑ Female

Weight (lbs): _____ Height (in.): _____ Allergies: _____

Primary Insurance: _____ Secondary Insurance: _____

ID#: _____ Phone #: _____ ID#: _____ Phone #: _____

FAX COPY OF INSURANCE CARD (FRONT & BACK)

☐ Lumbosacral Support — L0626

☐ Universal
☐ Small
☐ Medium
☐ Large
☐ X-Large

Doctor Initials:_____

☐ Figure-8 Clavicle Strap — L3650

☐ X-Small
☐ Small
☐ Medium
☐ Large
☐ X-Large

Doctor Initials:_____

☐ Shoulder Immobilizer — L3670

Doctor Initials:_____

☐ Foam Cervical Collar — L0140

☐ X-Small
☐ Small
☐ Medium
☐ Large
☐ X-Large

Doctor Initials:_____

☐ Rib Belt- Men & Women — L0210

☐ Small
☐ Medium
☐ Large
☐ X-Large

Doctor Initials:_____

☐ Hernia Support — L8300 / L8310

☐ Small
☐ Medium
☐ Large

Doctor Initials:_____

☐ Wrist Splint — L3908

☐ X-Small
☐ Small
☐ Medium
☐ Large
☐ X-Large

Doctor Initials:_____

☐ Knee Brace — L1810

☐ Small
☐ Medium
☐ Large
☐ X-Large
☐ XX-Large

Doctor Initials:_____

☐ Ankle Support — L1902

☐ X-Small
☐ Small
☐ Medium
☐ Large
☐ X-Large

Doctor Initials:_____

☐ Compression Stockings — A6545

☐ Moderate
☐ Firm
☐ 15-20 cm
☐ 20-30 cm
☐ 30-40 cm

Doctor Initials:_____

☐ Electric Heating Pad — E0210

Doctor Initials:_____

☐ Other:

_____
_____
_____
_____

Doctor Initials:_____

CLINICAL INFORMATION

ICD-10 Diagnosis

❑ _____
❑ _____
❑ _____

Clinical Notes to justify need for prescribed items:

_____
_____
_____

FAX COPY OF ALL RELATED CLINICAL/LAB INFO

PHYSICIAN INFORMATION

Physician Name: _____ Contact: _____ NPI#: _____

Address: _____
Address, City, State, Zip Code

Phone #: _____ Fax#: _____ Email: _____

Physician's Signature: _____ Date: _____

BY SIGNING, I AUTHORIZE the use of this document as a legal prescription, and I certify that the above prescribed equipment is medically necessary and reasonable 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 any insurer or authorized agents, if required.