DIAMOND Medical Equipment

Accepting Medicare
Phone: (480) 926-4363
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Standard Written Order

Today's Date: _____

Patient Name: _____ DOB: _____ Height: _____ Weight: _____

Diagnosis: _____ Length of Need: _____ Start/Discharge Date: _____

Wheelchair

☐ 16" ☐ 18" ☐ Non-Standard Seat Frame Width: ☐ 20" ☐ 22" ☐ 24"

☐ Hemi Height Wheelchair (< 65") ☐ Light Weight Wheelchair ☐ Heavy Duty Wheelchair (>250 lbs)
☐ Standard Wheelchair ☐ Fully Reclining Back ☐ Extra HD Wheelchair (>300 lbs)
☐ General Seat Cushion ☐ General Back Cushion ☐ Elevated Leg Rests
☐ Anti-Tippers ☐ Pressure Relief/Skin Protection Cushion ☐ Arm Trough

Walker

☐ Front Wheeled Walker ☐ Four Wheeled Walker w/ Seat Attachment ☐ Hemi Walker
☐ Platform; Left or Right (circle one) ☐ Heavy Duty Front Wheel Walker ☐ HD 4-Wheel Walker w/ Seat Attachment (>300 lbs)

Semi-Electric Hospital Bed

☐ Semi-Electric Hospital Bed (<350 lbs) ☐ HD Semi-Electric Hosp Bed (>350 lbs) ☐ Patient Lift with Sling
☐ Gel Overlay (Group I) ☐ APP&P (Group I) ☐ Low Loss Air Mattress (Group II)

Oxygen *(CMN is also required)*

☐ Home Oxygen LPM _____ via ☐ NC ☐ Continuous ☐ Portable with contents ☐ Nocturnal
Date Tested: _____ RA Rest: _____ RA Exertion _____ ☐ SVN Machine (nebulizer) Rx: _____

PAP Services

☐ CPAP _____ cm/H_2O ☐ BiPAP _____ cm/H_2O ☐ Heated Humidifier
☐ Nasal Mask ☐ Full Face Mask ☐ Nasal Pillows ☐ Head Gear ☐ Cushions
☐ Chin Strap ☐ Tubing ☐ Heated Tubing Filters: ☐ Disposable ☐ Reusable

Enteral Feeding

Formula: _____ Frequency: _____ Total cal/day _____ via tube into stomach
☐ Large Volume Pump ☐ IV Pole ☐ Supply Kit (Pump Feed) ☐ Supply Kit (Syringe Feed)

Orthotics

☐ LSO Qty _____ Lumbar Sacral Orthosis HCPCS L0650 ☐ TLSO Qty _____ Thoracic Sacral Orthosis HCPCS L0457
☐ Cervical Collar Semi-rigid, Thermoplastic Foam, Two Piece L0172
☐ Cervical Collar Semi-rigid, Thermoplastic Foam, Two Piece w/ Thoracic Extension L0174
☐ Knee Orthosis w/adjustable knee joints HCPCS L1833 ☐ Left ☐ Right
☐ L2397 Suspension Sleeve ☐ L2795 Full Knee Cap Control ☐ L2810 Condyler Pad
☐ Walking Boot HCPCS L4361 ☐ Left ☐ Right ☐ Knee Scooter
☐ AFO Multi Ligementous Ankle Support HCPCS L1906 ☐ Left ☐ Right
☐ Wrist - Hand Finger Orthosis, without joints - thumb splint HCPCS L3809 ☐ Left ☐ Right
☐ Wrist - Hand Orthosis, wrist lock-up non-molded HCPCS L3908 ☐ Left ☐ Right

Comments / Other Orders

(Please provide face-to-face chart notes that support medical necessity with the order)

I hereby certify that the services are medically necessary and are authorized by me. The patient is under my care and is in need of the services listed above.

Treating Practitioner Signature: _____ **Date:** _____

Treating Practitioner Printed Name: _____ **NPI #:** _____

Checklist of Items Required to Dispense Medicare

_____ Standard Written Order (SWO)
_____ Face Sheet – Demographics sheet
_____ Progress note with face to face evaluation for Durable Medical Equipment
_____ Copy of Insurance Card

Progress Note Language needed for Wheelchairs

_____ Has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADLs) such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home.
_____ Mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker.
_____ Home provides adequate access between rooms, maneuvering space, and surfaces for use of the manual wheelchair that is provided.
_____ Will significantly improve the beneficiary's ability to participate in MRADLs and the beneficiary will use it on a regular basis in the home.
_____ The beneficiary has not expressed an unwillingness to use the manual wheelchair that is provided in the home.
_____ The beneficiary has sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the manual wheelchair that is provided in the home during a typical day. Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function.
_____ OR, The beneficiary has a caregiver who is available, willing, and able to provide assistance with the wheelchair.

For Nonstandard Wheelchair Widths (20" or larger)

_____ Requires nonstandard seat frame width due to patient's hip width

For a Hemi Ht wheelchair Pt is 5'6" or shorter ADD

_____ Beneficiary requires a lower seat height (17" to 18") because of short stature or to enable the beneficiary to place his/her feet on the ground for propulsion.

For Light Weight wheelchair ADD

_____ Cannot self-propel in a standard wheelchair in the home; can and does self-propel in a light weight wheelchair.

For Heavy Duty and Extra Heavy Duty wheelchair ADD

_____ Pts weight is over 250lbs. **For Extra Heavy Duty ADD** _____ Pts weight is over 300 LBS

For Reclining back wheelchair ADD

_____ Pt Can NOT pressure relieve himself, or ____ Pt self-catheterizes.

Progress Note Language needed for Semi Electric Hospital Bed

_____ Has a medical condition which requires positioning of the body in ways not feasible with an ordinary bed.
_____ The beneficiary requires the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease, or problems with aspiration.
_____ Requires frequent changes in body position and/or has an immediate need for a change in body position due to _____.
_____ Severity of condition while is ordinary bed.

Progress Note Language Needed for Home Oxygen

_____ Room air sats are 88% or lower at rest. OR ____RA sat at rest____RA sat at exertion____Sat w O2
_____ Has an underlying lung disease (ie: COPD).
_____ Medical condition causes hypoxic symptoms and would benefit from oxygen therapies.
_____ Alternative treatment measures have been tried or considered and deemed clinically ineffective.
_____ Certificate of Medical Necessity (CMN)

Progress Note Language Needed for Low Air Loss Mattress

_____ Patient has multiple stage II ulcers on the trunk or pelvis, or_____has large stage III or IV ulcer on trunk or pelvis.
_____ Group 2 form and skin assessment.

For LSO Lumbar Sacral Orthosis Off the Shelf and TLSO

1. To reduce pain by restricting mobility of the trunk; or
2. To facilitate healing following an injury to the spine or related soft tissues; or
3. To facilitate healing following a surgical procedure on the spine or related soft tissue; or
4. To otherwise support weak spinal muscles and/or a deformed spine.

Knee Orthosis

Knee instability must be documented by examination of the beneficiary and objective description of joint laxity (e.g., varus/valgus instability, anterior/posterior Drawer test).
They will be denied if only pain or a subjective description of joint instability is documented.

AFO and Walking Boot

Ambulatory beneficiaries with weakness or deformity of the foot and ankle, who:
1. Require stabilization for medical reasons, and,
2. Have the potential to benefit functionally.