Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form

See instructions for completing Title XIX Home Health Durable Medical Equipment (DME)/Medical Supplies Physician Order Form. This order form cannot be accepted beyond 90 days from the date of the physician's signature.

Section A: Requested Durable Medical Equipment and Supplies

This section was completed by (check one): ☐ **Requesting Physician** ☒ **Supplier**

Client Information

Client Name:	Medicaid number:	Date of birth:

Supplier Information

Name: Landmark Healthcare Inc.	Telephone: 817-338-0007	Fax number: 866-338-0816
Address: 3515 NW Jim Wright Fwy		

TPI: 287123801	NPI: 1063575579	Taxonomy: 332BX2000X	Benefit Code:
QRP name:		QRP TPI:	QRP NPI:

I certify that the services being supplied under this order are consistent with the physician's determination of medical necessity and prescription. The prescribed items are appropriate and can safely be used in the client's home when used as prescribed.

DME/medical supplies provider representative signature:	Date:
DME/medical supplies provider representative name (Typed or Printed):	

Prescribing Physician Information

Name:	Telephone:	Fax number:

Item Number	HCPCS Code	Description of DME/medical supplies	Qty.	Price	Prior authorization required?	Beyond quantity limit?[1]	Custom item?[1]
1	E1390	Oxygen Concentrator, Monthly Rental	1/Mo	247.93	☑ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
2	E0431	Portable Oxygen, Monthly Rental	1/Mo	45.00	☑ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
3	E0443	Portable Oxygen Contents, Gas, 1 Mo Supply = 1	1/Mo	0.00	☐ Y ☑ N	☐ Y ☐ N	☐ Y ☐ N
4	E1353	********** Must enter "Regulator or Conserver"**********	1/Mo	0.00	☐ Y ☑ N	☐ Y ☐ N	☐ Y ☐ N

1. If "Yes," additional documentation must be provided to support determination of medical necessity.

Section B: Diagnosis and Medical Need Information

This is a prescription for DME/supplies and must be filled out by the prescribing physician.

Item Number[2] (From Section A)	Diagnosis	Brief Diagnosis Descriptor	Complete justification for determination of medical necessity for requested item(s)[2] (Refer to Section A, footnote 1)

2. Each item requested in Section A must have a correlating diagnosis and medical necessity justification.
Enter all *Item numbers* from the table in Section A that pertain to each diagnosis. A range of item numbers may be entered.

If applicable, include height/weight, wound stage/dimensions and functional/mobility status:

***Note**: The "Date last seen" and "Duration of need" items must be filled in.*	Date last seen by physician:
Duration of need for DME: _____ month (s)	Duration of need for supplies: _____ month (s)

By signing this form, I hereby attest that the information in Section "A", with the exception of the DME provider's signature, was complete at the time of my signature and is consistent with the determination of the client's current medical necessity and prescription. By prescribing the identified DME and/or medical supplies, I certify the prescribed items are appropriate and can safely be used in the client's home when used as prescribed.

Signature and attestation of prescribing physician:	Date:

Signature stamps and date stamps are not acceptable

Prescribing physician TPI:	NPI:	License number:

Medicaid Certificate of Medical Necessity for CPAP/BIPAP or Oxygen Therapy Form

Section A - (To Be Completed By Physician or Physician's Staff)		
Client Name:	Client Medicaid Number:	
Physician Information		
Name:	Telephone:	
Address:		
License Number:	TPI:	NPI:
Supplier Information		
Name: Landmark Healthcare Inc.	Contact Person:	
Address: 3515 NW Jim Wright Fwy		
Telephone: 817-338-0007	Fax number: 866-338-0816	
TPI: 287123801	NPI: 1063575579	
Taxonomy: 332BX2000X	Benefit Code:	

SECTION B- (To Be Completed By Physician)		
CPAP/BIPAP S Request		
Diagnosis:		
Date of Polysomnogram (Polysomnogram required for all CPAP requests) :		
If request is for BIPAP, explanation of the inability to tolerate CPAP:		
AHI/RDI:	Sleep Time (hours):	Total Apneas:
Obstructive apneas:	Lowest Oxygen Saturation (percent):	
BIPAP ST Request		
Diagnosis:		
If request is for BIPAP ST, explanation of the inability to tolerate BIPAP S:		
Date of Polysomnogram (If Applicable):		
Lowest Oxygen Saturation (percent): or Arterial PO2 (mm Hg):		
If prescribed for central sleep apnea	Central apneas/hr:	Longest central apnea: sec.
Oxygen Therapy Request		
Diagnosis:		
Lowest Oxygen Saturation at rest or with exercise (percent): or Arterial PO2 (mm Hg):		
Lowest Oxygen Saturation during sleep (percent): or Arterial PO2 (mm Hg):		
Flow rate (l/min.):	Via Nasal Canula Hours of treatment per day (estimated):	
Is oxygen therapy required for mobility within the home?	☐ Yes	☐ No
Is oxygen therapy required for mobility when leaving the home?	☐ Yes	☐ No
Prescribing Physician Signature:	Date:	
Submit with completed Title XIX Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form		