139 East Main Street
Forest City, NC 28043
Phone: 828-245-4591 / Fax: 828-245-1793
Toll Free Phone: 877-441-4815

ACHC ACCREDITED

DATE: _____-_____-_____

MD PROVIDER: _____***NPI #:**

_____

SPECIALTY: _____ UPIN #:

_____

PHONE #: _____ FAX #:

_____

PATIENT INFORMATION

NAME: _____ **DOB:** _____ SEX: ___MALE ____ FEMALE

HT: _____ WT: _____

ADDRESS 1: _____ADDRESS 2:

_____

CITY: _____ STATE: _____ ZIP CODE:

_____

SSN: _____-_____-_____ **PHONE #:**

_____

DIAGNOSIS: _____ LENGTH OF NEED (0-99/LIFETIME):

_____

ICD-9

_____

_____

ICD-10_____

_____

INSURANCE: _____ **ID #:**

_____

INSURED: _____ DOB INSURED:

_____

* DME ORDERS*

___**OXYGEN*****MUST USE SMITH'S DRUGS OXYGEN ONLY PHYSICIAN ORDER FORM**
___**NEBULIZER / SERIAL #** _____ _____KITS / SUPPLIES
___PARI VORTEX MDI HOLDING CHAMBER___SMALL ___MEDIUM ___LARGE (NO MASK)
___CPAP – CWP: _____ RELATED SUPPLIES: _____MASK:

_____

___BIPAP- PT. UNABLE TO TOLERATE / RELATED SUPPLIES: _____ MASK:

_____

___HOSPITAL BED __ SEMI-ELECTRIC __ EGG CRATE __ GEL OVERLAY MATRESS
___OVER THE BED TABLE __ BEDSIDE COMMODE ___ BATH BENCH ___LIFT CHAIR___CRUTCHES
___WHEEL CHAIR ___ STANDARD ___ ROLLING __WALKER ___W/SEAT ___ CANE __ REGULAR ___QUAD
___DIABETIC SUPPLIES___NIDDM: ___IDDM: ___TESTS PER DAY: __/__INS. DEP__NON INS. __DIABETIC SHOES
___OTHER_____

____

_____

PARENT/GUARDIAN/CAREGIVER SIGNATURE: _____
DATE:_____

☐ ***FACE TO FACE DOCUMENTATION AND NOTES* (**MEDICARE ONLY EFFECTIVE 07-01-13**)**
********DETAILS AND SPECIFICS ON THE DIAGNOSIS AND NEED FOR THE EQUIPMENT IS REQUIRED********

_____

_____

_____

_____

***PHYSICIAN'S SIGNATURE: _____**
DATE:_____

Websites: www.smithsdrugsfc.com and on @ http://www.facebook.com/smithsdrugs