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-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