Synergy Medical Supply

Toll Free (800) 443-3390
Toll Free Fax (800) 952-5352

*Please fax your patient's insurance and demographic information along with this form.

PATIENT INFORMATION

Start Date: _____ Account #: _____ DOB: _____

Patient Name: _____ Ordered By: _____ Height: _____ Weight: _____

Patient Phone: ( ) _____ Diagnosis/Diagnosis Code: _____

Address: _____ Duration of Need: _____

AIDS TO DAILY LIVING

- ☐ Walker E0135
- ☐ Hemi Walker E0135
- ☐ Walker Platform Attachment E0154
- ☐ Wheeled Walker E0143
- ☐ Wheeled Walker with Seat E0143-E0156
- ☐ Extra Wide Walker E0148
- ☐ Cane E0100
- ☐ Sidestepper E0135
- ☐ SM Base Quad Cane E0105
- ☐ LG Base Quad Cane E0105
- ☐ Offset Cane E0100
- ☐ Straight Cane E0100
- ☐ Crutches E0114
- ☐ Crutch Platform Attachment E0153
- ☐ Extra Wide Commode E0168
- ☐ Double Arm Commode E0165
- ☐ Bedside Commode E0163
- ☐ Confined to a single room or to one level of their home environment with no bathroom facilities
- ☐ Bed/Chair confined
- ☐ No indoor bathroom facilities

HOSPITAL BED

- ☐ Alternating Pressure Pad & Pump (APP) E0181
- ☐ Trapeze E0910
- ☐ Free-Standing E0940
- ☐ Sof Care E0197
- ☐ Patient Lift E0630
- ☐ Gel Overlay E0185
- ☐ Condition expected to last one month and patient requires aid in positioning
- ☐ Bed required to alleviate pain
- ☐ Requires bed to be lowered to chair/stand
- ☐ Condition requires HOB elevation up to 30 (CHF, COPD, Aspiration)
- ☐ Device needed to assist to sitting position, for changes in position, or getting in or out of bed.
- ☐ Semi-electric Hospital bed w/ mattress E0260
- ☐ Semi-electric Hospital bed w/o mattress E0261
- ☐ Full-electric Hospital bed w/ mattress E0265
- ☐ Full-electric Hospital bed w/o mattress E0266
- ☐ Variable Height Hospital bed w/ mattress E0255
- ☐ Variable Height Hospital bed w/o mattress E0256
- ☐ Heavy Duty Hospital bed w/ mattress E0303
- ☐ Heavy Duty Hospital bed w/o mattress E03010
- ☐ Extra Heavy Duty Hospital bed w/o mattress E03010
- ☐ Heavy Duty Hospital bed w/o mattress E03010

INCONTINENCE SUPPLIES

- ☐ Urinary Incontinence
- ☐ Bowel Incontinence

Also list DX causing incontinence: _____

Please indicate supplies requested: _____

WHEELCHAIR

Type & Weight Limit:
- ☐ Standard Wheelchair (up to 250lbs.) K0001
- ☐ Heavy Duty Wheelchair (over 250lbs.) K0006
- ☐ Hemi Height Wheelchair K0002
- ☐ Extra Heavy Duty Wheelchair (over 300lbs.) K0007
- ☐ Lightweight Wheelchair (under 250lbs.) K0003
- ☐ Seat Cushion E2601, E2602, E2603
- ☐ Back Cushion E2611

Size: (Seat & Width)
- ☐ Child
- ☐ 16
- ☐ 18
- ☐ 20
- ☐ 22
- ☐ 24

Options:
- ☐ Elevating leg rest K0195/E0990
- ☐ Brake Extensions E0961
- ☐ Stump Support E1020
- ☐ Super Hemi Height Under 17" K0056
- ☐ Reclining Back E1226
- ☐ Footrests w/ heel loops E0951
- ☐ Anti-tippers (pair) E0971
- ☐ Amputee Setback (Bi-lateral AKA) E0959
- ☐ Tall Seat (over 21") K0056
- ☐ Quick Release Axle K0108
- ☐ Pelvic Strap E0978
- ☐ Other:

☐ Condition confines client to bed or chair & wheelchair required to move about in residence.

Patient using ambulatory aid? ☐ Yes ☐ No If yes, please specify: _____

WHEELCHAIR

- ☐ Wheelchair required for use inside of home

Size: ☐ 17 ☐ 19

- ☐ Heavy Duty Transport Wheelchair - Gemco (over 300 lbs.) E1039
- ☐ Standard Transport Wheelchair (up to 250 lbs.) E0138

I certify that the medical necessity information above is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

Physician's Signature: _____ Date: _____

Physician's Printed Name: _____ Office Address: _____

Phone: ( ) _____ UPIN #: _____ City/State/Zip: _____