D.19 Addendum to Home Health (Title XIX) DME/Medical Supplies Physician Order Form

Section A—This section may be filled out by the DME/medical supplies provider or the prescribing physician.

Client name: _____ Medicaid Number: _____

Name of supplier/vendor: _____ Provider Medicaid Number: _____

Typed or printed name of DME/medical supplies provider representative: _____

I certify that the services being supplied under this order are consistent with the physician's medical necessity determination and prescription.

Signature of DME/medical supplies provider representative: _____ Date: _____

NHIC USE ONLY

HCPCS Code	Description Of Requested DME/Medical Supply	Quantity	Price	Approve	Deny	Comment

Section B—This section must be filled out by the physician prescribing the DME/supplies.

Description of DME/Medical Supplies Prescribed	Quantity	Customized
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

Typed or printed name of prescribing physician: _____

Signature of prescribing physician: _____ Date: _____

Physician signature and date stamps are not acceptable.

Prescribing physician's license number: _____