RICK'S MEDICAL SUPPLY

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North Bend, OR 97459
Phone: 541-756-9016
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DURABLE MEDICAL EQUIPMENT PRESCRIPTION

NAME: _____ DOB: _____

ADDRESS: _____ PHONE: _____

ICD-10 Code: _____ (Required) Length of Need: _____ Months (Required)

☐ STANDARD REQUEST ☐ EXPEDITED REQUEST - 72 hours (member's health is at immediate risk i.e. loss of life, limb, or eyesight imminent) *(fill out Justification below:)*

** justification within submitted documentation is required for Expedited processing. If your PA request does not meet Expedited criteria, it will receive Standard processing. Expedited requests are appropriate if the Standard Time Frame could seriously jeopardize a Member's life or health, or their ability to attain or maintain or regain maximum function.

JUSTIFICATION:

DIABETIC SUPPLIES: NON-INSULIN DEPENDENT**(ONCE PER DAY) INSULIN DEPENDENT**(THREE TIMES PER DAY)
PLEASE FAX CHART NOTES IF ABOVE GUIDELINE TESTING

MEMBER IS TO TEST: _____PER DAY INSULIN INJECTIONS:_____PER DAY

TEST STRIPS 50/box	☐	/month	LANCING DEVICE		
LANCETS 100/box	☐	/month	CONTROL SOLUTION		
ALCOHOL WIPES 100/box	☐	/month	REPLACEMENT BATTERY		
PEN NEEDLES 100/box	☐	/month			
SYRINGES 100/box	☐	/month			

INCONTINENT SUPPLIES

***BRIEFS** (tap-on) _____		***PULLUPS** (underwear) _____		***LINERS** _____	*ANY combo 200 per month
DISPOSABLE UNDERPADS (Chux) (100 per mo) ☐ or			WASHABLE UNDERPADS (8 PER YR) ☐		
GLOVES (2 BOXES PER MO) SM: ☐		MED: ☐		LG: ☐	

MISC SUPPLY (Check supply)

NEBULIZER	☐	NEB MASK	☐	NEB FILTERS	☐	
SPACER	☐	DISP. NEB CUP KIT	☐	PEAK FLOW METER	☐	
AUTOMATIC BLOOD PRESSURE MONITOR ☐						

PRESCRIBING PHYSICIAN: _____ Fax#: _____

SIGNATURE: _____ Date: _____