SALES | SERVICE | RENTALS
251 N. Trade St.
Matthews, NC 28105
Office/Fax 704-821-7777
www.Mobility-More.com

FAX COVER PAGE / DME ORDER REQUEST

Date:	Total Pages:
To:	From:
Fax:	Patient:
Phone:	Date of Birth:

Urgent	For Review	Please Reply

Dear Physician,
We have been asked to provide incontinence supplies to your patient named above. Medicaid requires that you complete the attached CMN and Order Form so that we can provide these supplies. On behalf of this patient, we are requesting your completion of the attached. Please explain the medical necessity for these supplies on question #30 of the CMN and in the patient's chart notes**. Please fax both the CMN/PA Form and Order Form back along with the relative patient chart notes.** Thank you for your cooperation and prompt response. We greatly appreciate your assistance in providing for this patient!

PLEASE COMPLETE ALL HIGHLIGHTED AREAS, SIGN AND FAX BACK
with RELATIVE CHART NOTES TO (FAX)# 704-821-7777
QUESTIONS PLEASE CALL 704-821-7777

YOU DO NOT NEED TO FAX BACK THIS COVER PAGE

Notice of Confidentiality
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Incontinence Supplies Order Form

Referral Source:	Consultant: Jay Buinicky
Phone #	Phone #

Patient Demographics

Name:			Phone:		
Street Address:			City:	State:	Zip:
DOB:	Sex: M F	Ht:	Wt:	Social Security #:	

Insurance Information

Primary Insurance Information: ❑ Medicare ❑ Medicaid	Secondary Insurance Information: ❑ Medicare ❑ Medicaid
Name:	Name:
Address:	Address:
Phone:	Phone:
Policy #:	Policy #:

SUPPORTING ICD-10 CODES / NARRATIVE DIAGNOSIS

1.	2.	3.	4.

DESCRIPTION OF ITEM	HCPCS CODE	QUANTITY
Adult Briefs/Pull Ups	Code _____________ Circle Size Below Small Medium Large XL	Up to 200 per month
Underpads	A4554	Up to 150 per month
Gloves	A4927	Up to 4 boxes per month

The patient named above is being treated under a comprehensive plan of care. I, the undersigned treating physician certify that the above prescribed is medically necessary for the patient. I believe that the following products are both reasonable and necessary for the overall patients well being, condition and/or rehabilitation. I certify that the patient's medical records reflect the need for the item ordered and will be made available upon request.

Physician Name:		NPI #:	
Address:	City:	State:	Zip:
Contact:	Phone:	Fax:	
Physician Signature:		Date:	

Fax to 704-821-7777 or email to orders@mobility-more.com

NC DMA Request for Prior Approval CMN/PA

Recipient Information **DMA372-131**

1. Recipient Last Name:_____________________________ 2. First Name:_____________________________

3. Recipient ID #_____________________ 4. Recipient Date of Birth:_______________ 5. Recipient Gender:__________

Diagnosis Information

	Diagnosis (code AND description)	Date of Onset	Primary?
1			
2			

Payer Information

6. Is this a Medicaid or Health Choice Request? Medicaid: ☐ Health Choice: ☐

Provider Information

7. Requesting Provider #:____NPI: ☐ Atypical: ☐ 8. Taxonomy: ______________________

9. Address: ____ 10. Nine Digit Zip Code: _________________

11. Billing Provider # (if different from requesting):________________________NPI: ☐ Atypical: ☐ 12. Taxonomy: ______________________

13. Address: ____ 14. Nine Digit Zip Code: _________________

15. Rendering Provider # (if different from billing):________________________NPI: ☐ Atypical: ☐ 16. Taxonomy: _____________________

17. Address: ____ 18. Nine Digit Zip Code: _________________

Requester Contact Information Name:__________________________________ Phone #:_____________________ Ext:_______

Medical and Functional Status

19. **Condition:** Stable: ☐ Unstable: ☐ Height: _________ Weight: ________

20. **Prognosis:** Terminal: ☐ Poor: ☐ Guarded: ☐ Fair: ☐ Good: ☐ Excellent: ☐

21. **Patient:** Requires positioning not feasible in ordinary bed: ☐ Unattended for long periods of time: ☐ Lives alone: ☐

22. **Equipment:** Necessary to retard deterioration of condition: ☐ Necessary for function: ☐ Specify_____________ Length of need: ______

23. **Mental:** Oriented: ☐ Forgetful: ☐ Disoriented: ☐ Agitated: ☐ Comatose: ☐ Depressed:☐ Lethargic: ☐ Infant: ☐ Other: ______

24. **Neurological:** Muscle Tone: Normal: ☐ Increased: ☐ Decreased: ☐ Fluctuating: ☐
Sensation: Normal: ☐ Abnormal: ☐ Specify:___________

25. **Respiratory:** Normal: ☐ SOB on minimal exertion: ☐ Tracheostomy: ☐
O2: ☐ Flow Rate:________ Frequency: __________ Test Date: ___________ Results: ______________

26. **Skin:** Normal: ☐ Other: ☐ Specify: ____________ Decubiti: ☐ Specify: __________________

27. **Ambulatory:** Complete bedrest: ☐ Up as tolerated: ☐
Transfers bed-chair (indep): ☐ Transfers bed-chair (w/assistance): ☐ Confined to wheelchair?☐ Hours per day: _____
Walks unassisted: ☐ Walks with assistive device: ☐ Specify: ____________ Max distance walked: __________

28. Can place of residence physically accommodate equipment being requested? ☐ Yes ☐ No

29. Patient's status will be monitored by physician while assistance is provided? ☐ Yes ☐ No

30. Medical Necessity of equipment: ____
____
____

Service Information

	From Date	To Date	New/Used/Rental	HCPCS Code	Equipment Description
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

_______________________ _________ ___________ _______________________ ______________ ___________

Requesting Provider's Signature Date Physician, PA, Nurse Practitioner Signature Date