DME STANDARD WRITTEN ORDER (SWO)

ORDER DATE:			Name of Practice / Facility:	
			Phone #:	
PATIENT DEMOGRAPHICS				
FIRST NAME:	***LAST NAME:***	M.I.	***PHONE:***	
Street Address:		City:	State:	Zip:
DOB:	Sex: M F	Ht:	Wt:	2nd Contact/Phone:
Primary Insurance: ❑ Medicare ❑ Medicaid ❑ Other			**Secondary Insurance:** ❑ Medicare ❑ Medicaid ❑ Other	
Name:			Name:	
Phone:			Phone:	
MBI/Policy #:			Policy #:	

SUPPORTING ICD-10 CODES

1.	2.	3.	4.

The patient named above is being treated under a comprehensive plan of care. I, the undersigned treating physician certify that the below prescribed is medically necessary for the patient. I believe that the following products are both reasonable and necessary for the overall patient's wellbeing, condition and/or rehabilitation. I certify that the patient's medical records reflect the need for the item ordered and will be sent to the DME provider along with this SWO.

Please list the medical equipment to be provided below:

_____

_____

_____

_____

_____

_____

QUANITY TO BE DISPENSED: _____ *LENGTH OF NEED:* _____

PHYSICIANS NAME:			***NPI #:***
Street Address:	City:	State:	Zip
Contact:	Phone:	Fax:	

PHYSICIANS SIGNATURE: _____ ***DATE:*** _____

FAX this SWO to 704-821-7777 or email to xxxxxxxxxxxxxxxxxxxx
info@mobility-more.com