PHYSICIAN INTAKE/ORDER FORM

Fax: 972-262-7160 Tel: 972-262-5053 E-mail: admin@straconmedsupply.com

REFERRAL NAME: **Phone#** **Fax#**

Beneficiary's Name _____

Address_____

City _____**State**_____**Zip**_____

Phone# _____ **Social Security #**___ ___ ___-___ ___-___ ___ ___ ___

Date of Birth ____/____/_____ **Male**____**Female**____**Weight** _____ **Height**_____

Next of Kin/Caregiver _____ **Phone #**_____

Medicare# _____ **Medicaid#**_____

Other Insurance_____ **Policy #** _____

ICD-10	Diagnosis Description	ICD-10	Diagnosis Description

List of Supplies to be dispensed to the patient:

1._____**2.**_____

3._____**4.**_____

5. _____**6.**_____

7._____**8.**_____

Frequency of use/Direction_____ **Refill Instructions**_____

Length of Use (Months) _____ **(99 for life) Size**_____ **Qty**_____

Treating Physician M.D OR DO _____

NPI_____**Address**_____

City_____ **State** _____ **Zip**_____

Phone_____ **Fax**_____

Treating Physician signature_____ **Date**_____

I certify that the patient is being treated for the diagnosis specified by me and the prescribed item is/are appropriate and can safely be used in the home when used as prescribed. The prescribed equipment is reasonable and necessary for accepted standards of medical practice and treatment of this patient's condition.

- ✶ Please specify item needed above with direction, size, refill, qty. & length of use
- ✶ Face to Face Examination required for Power Wheel Chair and Scooter
- ✶ CMN required for items such as Lift Chair, Ten's Unit
- ✶ Title XIX form required for Medicaid covered items such as incontinence products, shower chair, grab bar