WilBea Medical EQUIPMENT

Check off requested items & fax to (318) 746-8252. Please include a fax cover sheet with your contact information, patient face sheet & clinical notes supporting why the equipment is needed.

WRITTEN ORDER FORM FOR DME

PATIENTS NAME: _____ **DATE OF BIRTH:** _____

GENDER: ☐ M ☐ F **HEIGHT:** _____ **WEIGHT:** _____ **Length of Need:** _____

Insurance ID: _____ **ICD 10 DX:** _____

Size: ☐ Pediatric ☐ Adult ☐ Tall (^6"2") **Discharge Date:** _____

AMBULATION: *Heavy Duty items are provided for those <300 lbs.*

☐ ROLLING WALKER W/2 WHEELS ☐ ROLLATOR (WALKER W/ SEAT ATTACHMENT)

☐ PLATFORM ATTACHMENT FOR ROLLING WALKER ☐ LEFT ☐ RIGHT ☐ BOTH

☐ HEMI WALKER ☐ QUAD CANE ☐ CRUTCHES ☐ FOREARM CRUTCHES

COMMODES *Shower Chairs & Benches are covered by Medicaid Only*

☐ 3-N-1 BEDSIDE COMMODE ☐ HEAVY DUTY COMMODE (300 lbs.)

☐ DROP-ARM BEDSIDE COMMODE ☐ HD DROP ARM COMMODE

☐ SHOWER SEAT ☐ SHOWER CHAIR W/BACK ☐ TUB TRANSFER BENCH ☐ RAISED TOILET SEAT

MANUAL WHEELCHAIRS

☐ LIGHTWEIGHT ☐ STANDARD ☐ HEAVY DUTY ☐ EXTRA HEAVY DUTY

Sizes: ☐ 14" ☐ 16" ☐ 18" ☐ 20" ☐ 22" ☐ 24" ☐ 26" ☐ 28" ☐ 30"

☐ EXTRA SEAT WIDTH ☐ EXTRA SEAT DEPTH

MANUAL WHEELCHAIR ACCESSORIES

☐ RECLINING BACK ☐ BACK CUSHION ☐ SEAT CUSHION ☐ TRANSFER BOARD

☐ HEEL LOOPS ☐ ELEVATING LEG RESTS ☐ LIMB SUPPORT ☐ ANTI TIPPERS ☐ ARM TROUGH

TO ORDER POWER MOBILITY VEHICLES PLEASE VISIT US ON PARACHUTE

HOSPITAL BEDS & ACCESSORIES: *Heavy Duty weight must be over 300 lbs.

☐ STANDARD HOSPITAL BED ☐ FOAM MATTRESS ☐ HALF RAILS ☐ FULL RAILS

☐ HD FULL-ELECTRIC HOSPITAL BED ☐ DRY PRESSURE

☐ TRAPEZE BAR ☐ HD FREESTANDING FRAME W/TRAPEZE ☐ HYDRAULIC PATIENT LIFT

SUPPORT SURFACES: *For ulcers, burns, & severe skin conditions*

☐ ALTERNATING PRESSURE MATTRESS ☐ ALTERNATING PRESSURE PAD ☐ GEL OVERLAY

ORDERING PHYSICIAN: _____ **NPI:** _____

PHYSICIANS SIGNATURE: _____ **DATE:** _____

WilBea Medical EQUIPMENT

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RESPIRATORY SUPPLIES ORDER FORM

PATIENT NAME: _____ **DATE OF BIRTH:** _____

GENDER: ☐ M ☐ F **HEIGHT:** _____ **WEIGHT:** _____ **Length of Need:** _____

INSURANCE ID: _____ **ICD 10 DX'S:** _____

NEBULIZER & SUPPLIES

☐ Nebulizer Machine ☐ Nebulizer Administration Kit ☐ Ped Mask ☐ Adult Mask ☐ Trach Masks

COOL MIST HUMIDIFIER

☐ Cool Mist Humidifier (Aerosol Compressor/Large Volume Nebulizer)

☐ Supplies for Humidifier: Corrugated Tubing (A7010), Aerosol Cannister (A7007), Drain Bag (A7012) Trach Mask (A7525)

SUCTION & SUPPLIES

☐ Suction Machine ☐ Suction Canisters & Tubing ☐ Yankauer Catheters ☐ Suction Catheter Kits

OXYGEN THERAPY

Frequency: Check all that apply ☐ Continuous ☐ At Rest/Awake ☐ During Exertion ☐ During Sleep

☐ **Home Oxygen Concentrator:** Oxygen Flow Rate at: _____ Liters per Minute (LPM)

☐ **Portable Oxygen Concentrator:** Oxygen Pulse Dose Flow Rate at: _____ Liters per Minute (LPM)

☐ Nasal Cannula ☐ PAP Bleed In ☐ Oxygen Conserving Device ☐ Pulse Oximeter: (Sp02%) _____ BPM: _____

☐ **Portable Gaseous Oxygen System:** ☐ E Tank (lasts 5-6 hrs. on 2 (LPMs) ☐ Tank Cart ☐ Other _____

Qualifying Testing Criteria: Testing *MUST be documented in the medical record & sent separately.*

Date of Qualifying Test: _____

1. O2 SAT on Room Air at rest _____% (if 88% or lower, stop here)
2. O2 SAT on Room Air with Exercise (88% or lower) _____%
3. O2 SAT on _____Liters of O2 with Exercise _____%

PAP DEVICES & SUPPLIES

Please circle machine type and check off needed supplies for one year.

☐ **CPAP/Auto PAP:** _____ CWP ☐ **BiPAP/BiLevel:** IPAP_____ CWP EPAP_____ CWP

Humidifier: ☐ Patient Preference ☐ Heated Humidifier ☐ Passover Humidifier

Mask Interface: ☐ Patient Preference ☐ Other _____ Size: _____

☐ **SUPPLY QUANTITIES FOR 12 MONTHS:** A7027 Orl/Nasal Mask (1/3mo); A7028 Repl Oral/Nasal Mask (2/mo.); A7029 Repl Nasal Pillow (2/mo.); A7030 F/F Mask (1/3mo); A7031 FF Cushion (1/mo.); A7032 Repl. Nasal Cushion (2/mo.); A7033 Nasal Pillow (2/mo.); A7034 Nasal Mask (1/3mo); A7035 Headgear (1/6mo); A7036 Chin Strap (1/6mo); A7037/A4604 Tubing (1/3mo); A7038 Disposable Filters (2/mo.); A7039 Non Disposable Filters (1/6mo); A7046 Water Chamber (1/6mo)

Ordering Physician: _____ **NPI:** _____

Physician's Signature: _____ **DATE:** _____

WilBea Medical EQUIPMENT

Texas Medicaid members age 4 and older may qualify for incontinence supplies when a medical condition results in impairment of urination and/or stool.

PRESCRIPTION REQUEST FORM FOR DISPOSABLE INCONTINENCE PRODUCTS

Recipient Information

Name: _____ DOB: _____ Age: _____

Ins ID: _____ Hip Width: _____ Height: _____ Weight: _____

Prescribing Provider

Prescriber Name: _____ Phone: _____

Address: _____ Fax: _____

Medical Diagnoses causing the urine and/or fecal incontinence (Specify ICD 10 Code)

Primary: _____ **Secondary:** _____

Specify Urine/Fecal Incontinence diagnoses (Specify ICD 10 Code)

Primary: _____ **Secondary:** _____

Mobility: ☐ Ambulatory ☐ Minimal Assistance Ambulating ☐ Transfer Assistance ☐ Confined to bed/chair

☐ The patient is **self-sufficient**

☐ The patient is **unable** to assist caregiver

☐ The patient is **unable** to complete toilet training

☐ The patient **can** assist caregiver

Maximum Limit is 240 combined diapers/briefs/liners per month.

Mental Status/Level of Orientation

☐ Has the ability to communicate needs

☐ Sometimes can communicates needs

☐ Unable to communicate needs at all

Frequency of Anticipated Change:

During Daytime (6 am - 10 pm)	During nighttime (10 pm – 6 am)
_____	_____

Indicate Current Supportive Services:

☐ Home Health ☐ Skilled Nursing Services ☐ Personal Care Services ☐ Other: _____

List any medications and/or nutritional therapy that would increase urine or fecal output:

_____

Specify incontinence supply type, size, quantity per 24 hours and duration of need:

SUPPLY STYLE:	TYPE:	SIZE:	Qty Per Day	LENGTH OF NEED
☐ Diapers			_____	_____ Months
☐ Pull Ups	☐ Child	☐ 3T ☐ 4T ☐ 5T ☐ 6T ☐ 7T	_____	_____ Months
☐ Liner/Shield/Pad	☐ Youth		_____	_____ Months
☐ Wipes	☐ Adult	☐ XS ☐S ☐ M ☐ L ☐ XL ☐ XXL	_____	_____ Months
☐ Under pads			_____	_____ Months

By my signature I attest that I have seen the patient, and the item prescribed is medically necessary. I have personally completed this request, and a copy will be maintained in the patient's medical record.

Ordering Physician: _____ **NPI:** _____

Prescriber's Signature: _____ **Date:** _____

Please complete this Incontinence order form and the Home Health Services (Title XIX) DME/Medical Supplies Prescribing Provider Order Form. Attach the patient's clinical notes and fax to (318)746-8252

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WRITTEN ORDER FOR URINARY CATHETERS

Patients Name: _____ **Date of Birth:** _____ ☐ Male ☐ Female

Insurance ID: _____ **Height:** _____ **Weight:** _____ **Length of Need:** _____

PRIMARY DIAGNOSIS: ☐ Urinary Retention ☐ Urinary Incontinence ☐ Other _____

SECONDARY DX (ICD 10): _____

INTERMITTENT & COUDE QUALIFICATIONS

☐ Does the patient have a latex allergy?
☐ Has the patient been instructed on how to use the supplies?
☐ Is the patient being cared for by a home health agency?
☐ Is the patient able to catheterize with a straight tip?
☐ Is the incontinence expected to be medically or surgically corrected for the patient within the next 3 months?

CLOSED SYSTEM QUALIFICATIONS

☐ Does the patient have a history of distinct, recurrent UTI's?
☐ Is the patient immunosuppressed?
☐ Does the patient have radiologically documented vesico-ureteral reflux while on a program of intermittent catheterization?
☐ Is the patient a spinal cord injured female with neurogenic bladder who is pregnant?

INTERMITTENT CATHETER	BRAND/ITEM	FRENCH	LENGTH	FREQUENCY
☐ Intermittent Straight Tip	_____	☐ 6 Fr	☐ 6"	☐ 2 per day/60 month/180 per 3 mts
☐ Intermittent Coude Tip	_____	☐ 8 Fr	☐ 10"	☐ 3 per day/90 month/270 per 3 mts
☐ Closed System Cather	_____	☐ 10 Fr	☐ 14"	☐ 4 per day/120 month/360 per 3 mts
☐ Lubricant	☐ Tube ☐ Packet	☐ 12 Fr	☐ 16"	☐ 5 per day/150 month/450 per 3 mts
☐ Insertion Kit	1 Per Cath	☐ 14 Fr	☐ 18"	☐ 6 per day/180 month/540 per 3 mts
INDWELLING CATHETER	**BRAND/ITEM**	☐ 16 Fr	Other ____	Other _____
☐ Foley Catheter		☐ 18 Fr		
☐ Two-Way ☐ 3-Way	_____	☐ 20 Fr	Comments: _____	
☐ Latex ☐ Silicone		☐ 22 Fr	_____	
☐ Foley Insertion Tray	1 Per Cath	☐ 24 Fr	_____	
☐ With Bag ☐ Without Bag		Other ____	_____	

EXTERNAL CATHETERS		BRAND/ITEM	SIZE		FREQUENCY
☐ Male External Catheters		_____	☐ 25mm ☐ 29mm ☐ 32mm ☐ 36mm ☐ 41mm		35 per month
☐ Leg Bag	☐ Ext Tubing	_____	☐ 600 mL	☐ 900mL	1 per month
☐ Bed Drain Bag	☐ Ext Tubing	_____	☐ 2000 mL	☐ 4000 mL	1 per month

By signing below, I (Physician) Authorize the use of this document as a legal prescription and certify that the above prescribed supplies are medically necessary and reasonable. I will maintain an original signed copy of this order in my medical records.

Ordering Physician: _____ **NPI:** _____

Physician's Signature: _____ **DATE:** _____

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Enteral Feeding Equipment / Medicaid Oral Nutrition

IMPORTANT SUPPLIER SCOPE: Tube feeding formula is NOT supplied. For tube-fed patients, we can provide the feeding pump, IV pole, and the FIRST SET of feeding bags for initial setup only. Ongoing feeding bags, syringes, feeding tubes, extension tubing, and other enteral supplies are not supplied. Oral nutrition products are available for Medicaid patients only, subject to coverage and qualification.

Certification Type/Date: ☐ Initial ☐ Revised ☐ Recertification **Date:** _____

Patient Name: _____ **Date of Birth:** _____

Insurance ID: _____ **Length of Need:** _____

Gender: ☐ Male ☐ Female **Height / Weight / Target:** _____ / _____ / _____

Diagnosis Codes: _____

A. ORAL NUTRITION - MEDICAID PATIENTS ONLY

1. Oral nutrition product(s): _____

2. Flavor (if applicable): _____ Monthly amount/quantity: _____

3. Calories from oral nutrition products per day: _____

4. Does the patient have documented food allergies/intolerances? ☐ Yes ☐ No If yes, list: _____

B. ENTERAL FEEDING EQUIPMENT- COMPLETE FOR TUBE-FED PATIENTS

1. Does the patient have a permanent (3 months or greater) non-function or disease of the structures that normally permit food to reach or be absorbed from the small bowel? ☐ Yes ☐ No

2. Is there documentation in the medical record supporting permanent disease of the gastrointestinal tract causing severe enough malabsorption to prevent maintenance of weight and strength commensurate with the patient's overall health status? ☐ Yes ☐ No

3. Does the patient have documented food allergies/intolerances? ☐ Yes ☐ No If yes, list: _____

6. Method of administration: ☐ Pump ☐ Gravity ☐ Bolus (Syringe)

7. If pump is used, administration rate: _____ ml/hour x _____ hours

Initial Equipment Requested: Tube feeding formula and ongoing supplies must be obtained from another supplier.

Equipment		
☐ Enteral Feeding Pump	☐ IV Pole	☐ 30 Feeding Bags OR ☐ 30 Feeding Syringes

Ordering Physician: _____ **Date:** _____

Physician's Signature: _____ **NPI:** _____