



1-888-BINSONS
Fax: 586-755-2322

DETAILED WRITTEN ORDER PRIOR TO DELIVERY

Patient Name _____		DOB _____	
Account Number _____		Height _____ Weight _____ Order Date _____	
<input type="checkbox"/> Face Sheet/Demographics/Chart Notes Attached ■ Chart notes must include the need for equipment being ordered and MUST BE ATTACHED FOR OVER QUANTITY			
<input checked="" type="checkbox"/> I, the Physician, have treated this patient for a condition that supports the need and have discussed the need for this medical equipment with the patient and caregivers. I have documented the following information and the need for this equipment in the patient's most recent chart notes. Date of visit prior to order: _____			
***MUST BE FILLED OUT FOR MEDICAID PATIENTS ONLY: Reason for Medical Necessity (other than diagnosis): _____			
DIAGNOSIS			
PRODUCTS			
LENGTH OF NEED <input type="checkbox"/> 12 Months <input type="checkbox"/> Other _____ 99 = Lifetime FREQUENCY OF USE _____			
NOTES			
PRESCRIBING PHYSICIAN'S INFORMATION			
Name and Credentials _____		NPI No. _____	
Telephone No. _____		Fax No. _____	
Signature _____		Signature Date _____	
(Stamped Signature Not Accepted)			