BECN 20219013022

BINSON'S Medical Equipment & Supplies Since 1953

26834 Lawrence Center Line, MI 48047
1-888-246-4447
Fax: 586-755-4450

BECN 20219013022

Fax Completed Form To: 1-800-882-7071

EQUIPMENT & SUPPLY DETAILED WORK ORDER

(All information documented on this form must be in the patient's medical record & chart notes supplied)

reset form

Order Date _____ Account # _____

Patient Name _____ Patient DOB _____

Phone _____ Sex _____ Height _____ Weight _____ Insurance No. _____

Address _____ City _____ State _____ Zip _____

FOR MEDICAID PATIENTS ONLY - REASON FOR MEDICAL NECESSITY OTHER THAN DIAGNOSIS _____

OXYGEN

Diagnosis _____ Duration _____ 1-99 mos (99=lifetime)

☐ Concentrator & Portables ☐ Overnight Oximetry
☐ Conserving Device/Test to maintain O2 at 90% or _____ ☐ Nocturnal Oxygen (at night)
☐ Humidification LPM _____ hours/day _____ Use oxygen via ☐ Cannula

Test taken at ☐ Rest ☐ Exercise ***or*** ☐ Exercise w/O2 ***Please include documentation of all three results if the test was taken with exercise.***

PAP

Diagnosis _____ Duration _____ 1-99 mos (99=lifetime)

☐ CPAP ☐ BiPAP ☐ BiPAP ST ☐ Other _____ ☐ New Set Up ***or*** ☐ Repair/Replace
Settings _____ ☐ Heated Humidifier

SUPPLIES

☐ Full Face Mask (1/3 mos) ☐ Face Mask Interface for Full Mask (1/1mos) ☐ Nasal Mask (1/3 mos)
☐ Full Face Cushion (1/1 mos) ☐ Nasal Cushion (2/1 mos) ☐ Nasal Pillow (2/1 mos) ☐ Nasal Pillow Cushion (2/1 mos)
☐ Disp. Filter (2/1 mos) ☐ Tubing (1/3 mos) ☐ Heated Tubing (1/3 mos) ☐ Chin Strap (1/6 mos) ☐ Headgear (1/6 mos)
☐ Humidifier Chamber (1/6 mos)

VENTILATOR

Diagnosis _____ Duration _____ 1-99 mos. (99=lifetime)

☐ Ventilator & Supplies (Circuits & Filters) ☐ E0465 (Invasive) ☐ e0466 (Non-Invasive)

Primary Mode

Mode _____ Rate _____ Volume _____ I-Time _____ Peep _____ Pressure Support _____ AVAPS _____

Secondary Mode

Mode _____ Rate _____ Volume _____ I-Time _____ Peep _____ Pressure Support _____

☐ HME
☐ Trach Tube Size _____ (1/month) ☐ Inner Cannula Size _____ (60/month)
☐ Trach Tube Holders (30/month)
☐ Trach Care Kits (30/month)
☐ 3 ML Flushes of Normal Saline (Box of 100/month)
☐ 4 X 4 Split Gauze Pads (50 each/month)

SUCTION

Diagnosis _____ Duration _____ 1-99 mos. (99=lifetime)

☐ Suction Machine
☐ Suction Catheter Size _____ (90/month) ☐ Cannister (1/month) ☐ Tubing (1/month) ☐ Filter (1/month)

HUMIDITY TO TRACH

☐ Compressor
☐ Tubing (100 ft/quarter) ☐ Large Volume Nebulizer (2/month) ☐ Drain Bag (1/month) ☐ Trach Mask (1/month)

PHYSICIAN SIGNATURE

(A signature is required on pages 1 &2 if ordering from both.)

Physician Name _____ NPI # _____
Address _____ Phone _____
Physician Signature _____ Date _____
(No signature or date stamps)

BECN 20219013022

BECN 20219013022

BINSON'S Medical Equipment & Supplies Since 1953

26834 Lawrence
Center Line, MI 48047
1-888-246-4447
Fax: 586-755-4450

Florida Fax: 1-407-691-3021
Indiana Fax: 1-574-365-6202

BECN 20219013022

EQUIPMENT & SUPPLY DETAILED WORK ORDER

(All information documented on this form must be in the patient's medical record & chart notes supplied)

Order Date _____ Account # _____

Patient Name _____ Patient DOB _____

Phone _____ Sex _____ Height _____ Weight _____ Insurance No. _____

Address _____ City _____ State _____ Zip _____

FOR MEDICAID PATIENTS ONLY - REASON FOR MEDICAL NECESSITY OTHER THAN DIAGNOSIS _____

PRESSURE REDUCING MATTRESS GROUP 1

☐ Alternating Pressure Pad & Pump ☐ Gel Mattress ☐ Foam Mattress

NOTE: #1, #2, or #3 must be checked. If #2 or #3 are checked, one of the #s 4-7 must also be checked to qualify for a mattress.

Please include a copy of the most recent chart notes that justify the checked conditions.

1. ☐ Completely immobile
2. ☐ Limited mobility (cannot independently make changes in position)
3. ☐ Any pressure ulcer on the trunk or pelvis
4. ☐ Impaired nutritional status
5. ☐ Fecal or urinary incontinence
6. ☐ Altered sensory perception
7. ☐ Compromised circulatory status

Note: If none of the above applies, please attach a separate sheet documenting the medical necessity for the items ordered

PRESSURE REDUCING MATTRESS GROUP 2

☐ Low Air Loss Mattress ☐ Other _____ Diagnosis _____ Duration _____ 1-99 mos (99=lifetime)

Please check all conditions that apply to this patient (Coverage for #3 is limited to 60 days post-op.)

1. ☐ Multiple non-healing stage II ulcers on trunk or pelvis while on a group 1 surface with an ulcer treatment plan that includes: ongoing assessment by healthcare provider, turning & positioning, wound care, moisture & incontinence management, and nutritional intervention.
2. ☐ Large or multiple stage III or IV ulcers on the trunk or pelvis
3. ☐ Myocutaneous flap/skin graft for ulcer on trunk or pelvis within 60 days and on group 2 or 3 support surface before discharge from hospital/nursing facility.

AMBULATION AID

Diagnosis _____ Duration _____ 1-99 mos (99=lifetime)

☐ Folding Wheeled Walker w/Seat ☐ Folding Wheeled Walker, No Seat ☐ Standard Walker

☐ Knee Walker ☐ Standard Cane ☐ Quad Cane ☐ Crutches Other _____

Walker Accessories ☐ Glide Brakes ☐ Other _____

ENTERAL

Diagnosis _____ Duration _____ 1-99 mos (99=lifetime)

Insurance Qualifications ☐ Swallow Study ☐ SLP Report ☐ RD Assessment

Formula or Equivalent Formula _____ If pump, Goal Rate per hour _____ or Cans per Day _____

☐ Pump, Pole, Bags & Syringes ☐ Gravity Fed with Pole, Bags & Syringes ☐ Bolus Fed with Syringes

Tube Type: ☐ N/G Tube ☐ PEG/G Tube ☐ J Tube ☐ ENFit ☐ Legacy ☐ Other _____

WHEELCHAIR

Diagnosis _____ Duration _____ 1-99 mos (99=lifetime)

WHEELCHAIR BASE

☐ Standard Chair ☐ Reclining Chair ☐ Heavy-Duty Chair >250 lbs. or severe spasticity ☐ Extra Heavy-Duty Chair >300 lbs. ☐ Other _____

ACCESSORIES

☐ Anti Tippers ☐ Brake Extensions ☐ Elevated Leg Rest: ☐ Left ☐ Right ☐ Bilateral ☐ Stump Support: ☐ Left ☐ Right ☐ Bilateral ☐ Head Rest

☐ General Use Foam Seat Cushion ☐ General use Foam Back Cushion ☐ Skin Protection Seat Cushion *(Patient has decubitus ulcers or history of decubitus ulcers on the lower back/sacrum, hip and/or buttock area)* ☐ Seat Belt ☐ Reclining Back ☐ Oxygen Cylinder Holder ☐ Removable Desk Arms ☐ Other _____

OTHER

Diagnosis _____ Duration _____ 1-99 mos (99=lifetime)

OTHER EQUIPMENT _____ Quantity _____ Frequency _____

Special Instructions _____

PHYSICIAN SIGNATURE

(A signature is required on pages 1 &2 if ordering from both.)

Physician Name _____ NPI # _____

Address _____ Phone _____

Physician Signature _____ Date _____

BECN 20219013022