Hometown Medical Equipment

Tricare® preferred network provider
We proudly accept:
TRICARE®

506 Manchester Expressway Suite B-13 Columbus, GA 31904
Phone: 706-507-2222 or 844-260-9280 / Fax: 706-507-2233
Website: http://www.htmeq.com/ Email: info@htmeq.com

PHYSICIANS ORDER

Today's Date: _____

Patient's Full Name: _____ **D.O.B:** _____

Patient's Address: _____

Sponsor SSN w/Sponsor DOB OR Patient Benefit # w/Sponsor DOB: _____ **Patient's Phone#:** _____

Email Address: _____ **Due Date:** _____

Check all that apply:

	EQUIPMENT DESCRIPTION	ADDITIONAL INFO
	(√) CHECK THE PATIENT TYPE, STYLE, AND QUANTITY NEEDED **PLEASE STATE HEIGHT & WEIGHT Height _____ Weight _____** ****Depending on the compression garment type the following information is needed: Please provide SHOE SIZE _____** **ANKLE CIRCUMFERENCE _____ CALF CIRCUMFERENCE _____ THIGH CIRCUMFERENCE _____** **CALF LENGTH _____ LEG LENGTH _____ THIGH LENGTH _____**	
☐	**KNEE LENGTH COMPRESSION HOSE***** 18-30 MMHG **OPEN TOE ONLY**	☐ **QTY (_____)**
☐	**KNEE LENGTH COMPRESSION HOSE***** 18-30 MMHG **CLOSED TOE ONLY**	☐ **QTY (_____)**
☐	**NON MATERNITY COMPRESSION FULL LENGTH HOSE** 18-30 MMHG	☐ **OPEN TOE** ☐ **CLOSED TOE** ☐ **QTY (_____)**
☐	**MATERNITY COMPRESSION FULL LENGTH HOSE** 18-30 MMHG	☐ **OPEN TOE** ☐ **CLOSED TOE** ☐ **QTY (_____)**
☐	**COMPRESSION GARMENT (Indicate the compression type & amount of compression)**	☐ **(_____) MMHG** ☐ **QTY (_____)**
☐	**OTHER (Indicate the compression type & amount of compression)**	☐ **(_____) MMHG** ☐ **QTY (_____)**
☐	**POSITIONING PILLOW** ☐ **INCLINE WEDGE** ☐ **LEG WEDGE** ☐ **OTHER**	_____

Length of Need: _____ ***(example: Lifetime or 99 months)***

Physician Name Printed:		**Phone #:**	
Physician Signature:		**Date:**	
Physician NPI:		**State:**	
Physician Address:		**MTF/Practice Name:**	

DIAGNOSIS:

☐ R60.9	•Edema, unspecified	☐ R60.9	•Weakness
☐ I87.2	•Venous Insufficiency (chronic) (peripheral)	☐ M79.606	•Pain in leg unspecified
☐ I87.319	•Chronic venous hypertension (idiopathic) with ulcer of unspecified lower extremity	☐ I82.409	•Other venous embolism & thrombosis
☐ I86.8	•Varicose veins lower extremities with other complications	☐ I86.8	•Pelvic and Perineal Pain
☐ I83.813	• Varicose Veins Lower Extremities with pain	☐ M53.3	•Sacrococcygeal Disorders •Coccydynia
☐ O16.9	•Unspecified maternal hypertension, unspecified trimester	☐ G25.81	•Restless Leg Syndrome
☐ M53.3	•Conditions complicating pregnancy /Low Back / Hip Pain	☐ M54.9	• Dorsalgia, unspecified
☐Other DX	Please state:_____	☐Other DX	Please state:_____
☐Other DX	Please state:_____	☐Other DX	Please state:_____

NOTE: Please complete & fax to our office. Thanks

VbZ0200612