DME Order Form

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Weymouth, Ma 20188
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APEX MEDICAL PRODUCTS, INC

Referral Source_____ **Phone_(_____)_____ Date**_____

Patient Name_____ **Phone_(_____)_____**

Height _____ **Weight**_____ **DOB**_____

Patient's Diagnosis_____

Patient's Home Address (must be the same as Medicare has on file)

Street_____City_____ State MA Zip_____

Next of kin or best contact for delivery

Name_____ Relation _____Phone_(_____)_____

Delivery Address ☐ **check if same as home address**

Facility_____

Street_____City_____ State MA Zip_____

- Discharge Date_____/_____/_____

Clinical Information

PCP_____ **NPI**_____

Ordering Doctor_____ **NPI**_____

Equipment Requested

_____

_____

_____

PRIMARY INSURANCE **SUPPLEMENTAL INSURANCE**

Company Name _____ _____

Policy/Group # _____ _____

Notes: