GROVE MEDICAL

1089 Park West Blvd

Greenville, SC 29611

Phone: (864)269-0283 Fax: (864)272-1569

Medicare Part B Detailed Written Order for DME Supplies

Patient Name: _____ Patient's DOB: _____Start Date: _____

Facility Name: _____ Contact: _____ Facility Telephone #: _____

Patient's Clinical ICD-10 Diagnosis: _____

ITEM	Usage Per (Please list usage by day, week, month) (e.g. Bandage XYZ 1 per day)	Quantity per Month

("as needed" or "PRN" orders are not acceptable)

Length of need: _____ Number of refill(s): _____

***Medicare Lifetime equals 99 months**

***SC State Medicaid maximum length of need cannot exceed 12 months**

Physician's Name (Printed): _____ Physician's NPI #: _____

Address: _____ City: _____ State: _____ Zip: _____

Physician's Signature: _____ Date: _____

Substitutions Permitted: Yes No

Required: A current History and Physical and/or Progress Notes, signed and dated by the doctor must be included. Please make sure the text references the patient's current condition as it pertains to this order.