2577 S. Hamilton Road
Columbus OH, 43232
Website: www.CresthavenMedical.com
Phone: 614-600-1544 | Email: orders@Cresthavenmedical.com

DME PRESCRIPTION ORDER FORM

Patient Information **(BOLD Required):**:

Last Name: ______________________ **First Name**: ________________**Middle initial:**_________

Address: ________________________ City: ________________State: ___ **Zip Code**: ___________

DOB: ____________________ Phone: ________________ Email (Optional):____________________

Insurance (Medicare/Medicaid/BWC/OTHER):____

ID #: ______________________________________ Group #: _______________________________

Length of Need (Daily/Weekly/Monthly/Lifetime): ____________________________________

Diagnosis Code(s)/ ICD-10:/ ____

Item(s) Requested:

1. ______________________ **HCPC Code(s)**: ___________**Usage Per Day:**_________ **Refill** ___
2. ______________________ **HCPC Code(s)**: ___________**Usage Per Day:**_________ **Refill** ___
3. ______________________ **HCPC Code(s)**: ___________**Usage Per Day:**_________ **Refill** ___
4. ______________________ **HCPC Code(s)**: ___________**Usage Per Day:**_________ **Refill** ___
5. ______________________ **HCPC Code(s)**: ___________**Usage Per Day:**_________ **Refill** ___
6. ______________________ **HCPC Code(s)**: ___________**Usage Per Day:**_________ **Refill** ___

I certify that the above prescribed equipment is medically indicated and supports Standards of medical practice for this diagnosis.

Name of Requestor: ______________________________ **Phone**: __________________________

Signature: ____________________ **NPI#:**_________________________ **Date:** _________________

Hospital/Facility Name: ____

Please fax completed form to 614-600-1645

scan for blank form