

### Formulary for Request Durable Medical Equipment (DME)

Member Name:		Identification Number:		Date:	
<input type="checkbox"/> Female <input type="checkbox"/> Male		Phone Number:			
Address:		Weight:	Height:	Allergies:	
Name of Requesting Physician:		Referral Source:			
		<input type="checkbox"/> Doctor's Office <input type="checkbox"/> Hospital <input type="checkbox"/> Skilled Nursing Facility <input type="checkbox"/> Nursing Home			
Address:		Phone Number:		Fax Number:	
Diagnosis Codes:		Diagnosis:			
Referral to:		Phone Number:		Fax Number:	
Discharge Pending: <input type="checkbox"/> Yes <input type="checkbox"/> No		Facility's Name:		Admission Date:    /    /      Discharge Date:    /    /	

### Home Nutrition: (Include Nutritional Evaluation, Calories and Special Diet)

<input type="checkbox"/> Nutritional Evaluation <input type="checkbox"/> Parenteral Nutrition <input type="checkbox"/> Enteral Nutrition <input type="checkbox"/> Feeding Machine			
Name:	Rate:	Calories:	Intake Method:

### DME: (Check Applicable Equipment)

Walker Type:	CPM/Degrees: _____	Flexion: _____	Extension: _____
Wheelchair Type:	Tens/leads: _____	Settings: _____	Frequency: _____
Commode:	Suction Pump Catheter: _____ Size: _____		
Bed Type:	<b>Blood Glucose Monitoring</b>		
Cane/Crutches	<b>Testing Frequency</b>		
Seat Lift:	Glucometer	QD	Diabetic: <input type="checkbox"/> Yes <input type="checkbox"/> No
Lifter:	Lancets Device	BID	
Grab Bars:	Strips	TID	Insulin Dependant: <input type="checkbox"/> Yes <input type="checkbox"/> No
Uro/Ostomy (size):	Lancets	QID	
Others:	Control Sol.		

### Oxygen

Type: <input type="checkbox"/> Gas <input type="checkbox"/> Liquid <input type="checkbox"/> Other: _____	↑ _____ C-PAP    _____ cmH2O    _____ Bi-PAP    _____ Ipap    _____ Epap
Via: <input type="checkbox"/> Nasal Cannula <input type="checkbox"/> Ventury Mask : _____	Treatment Frequency: _____ /Days    RR: _____ /min
LPM: _____ / Hours: _____ / Days: _____	Ramps Setting: _____
Tank Size: _____ Quantity: _____ / ↑ Concentrator _____	Mask Size: _____ Head Gear: _____
Oximetry: Sat. O <sub>2</sub> _____ %    ↑ ABG's / PO <sub>2</sub> : _____	Length of Need: _____
Length of Need: _____	O <sub>2</sub> LPM: _____ ↑ Humidifier: _____
O <sub>2</sub> : ↑ Humidifier    ↑ Conserving Device	<b>Include: Sleep study, results/neuromuscular condition that justifies the use of equipment.</b>

**Nebulizador**    ↑ Duration 2 month \_\_\_\_\_  
**Albuterol 0.083% or 2.5mg/3ml**  
 Frequency: \_\_\_\_\_  
**Ipratropium 0.02% or 0.5mg.2.5ml**  
 Frequency: \_\_\_\_\_  
**Albuterol 2.5 mg/3ml / Ipratropium 0.5mg**  
 Frequency: \_\_\_\_\_  
**Budesonide 0.25mg/2ml or 0.5 mg/2ml**  
 Frequency: \_\_\_\_\_  
**Xopenex 0.31/3ml or 0.63mg/3ml or 1.25 mg /3ml**  
 Frequency: \_\_\_\_\_

Provider Name: (Printed)
Signature/License/NPI Number:

### Ventilators (Patient Evaluation Required)

SIMV: _____ ↑	CMV: _____
Specify: _____	Tvol: _____
Respiratory Rate: _____	FI02%: _____
Pressure: _____	Peep: _____
Other: _____	

### Preauthorization Use Only

<input type="checkbox"/> Approved <input type="checkbox"/> Denied	Authorization Number:
Determination Date:	Health Plan Coordinator Name: (Printed)

**Platino & Non Platino Members Forms Send To: Clinical Medical Services Fax. 787-622-3449**