



DASCO HOME MEDICAL EQUIPMENT QUICK SCRIPT



Our family serving yours since 1987

Patient Name: _____ **Phone/Cell #** _____

Address: _____ **Ht** _____ **Wt** _____

Diagnosis: _____ **ICD-9:** _____

Diagnosis: _____ **ICD-9:** _____

Date prescribed: ____ / ____ / ____ **Length of need:** _____ (1-99, 99= lifetime)

Copy of demographic information? Yes No

Copy of insurance information? Yes No

Oxygen (& related supplies)

____ lpm continuous (or) ____ hpd via nasal cannula
 O2 Sat: _____ % rest w/ exertion sleeping
 Date of test: ____ / ____ / ____ By: _____
 Portable Conserving device

Ambulation Devices

Crutches Cane Quad cane
 Walker w/ Wheels Seat
 Wheelchair Lightweight Heavy duty
 Elevating leg rest Seat & back cushion

Beds & Accessories

Semi-electric hospital bed
 Trapeze Eggcrate Gel overlay APP&P

PAP Machines

Cpap _____ cmh2o **Bipap** ____ / ____ cmh2o
 Cool Humidifier Heated Humidifier
 Mask Headgear Filters Tubing Chin Strap
 Cushions Nasal pillows Water Chamber Interface

Aids to Daily Living

Bedside Commode; patient is room or floor confined or unable to access facilities
 Shower chair Raised Toilet Seat
 Other _____

Neb & Meds (including tubing, filters & all related supplies)

*****Order good for 90 day supply*****

Meds _____ Strength _____ Refills _____
 Directions: BID TID QID Q4H PRN Other _____
 Quantity: 180 270 360 540 Other _____

Meds _____ Strength _____ Refills _____
 Directions: BID TID QID Q4H PRN Other _____
 Quantity: 180 270 360 540 Other _____

*Albuterol 0.083% Ipratropium 0.02% Xopenex 1.25 mg
 Budesonide 0.25 mg DuoNeb *Perforomist 20mcg/2ml *Brovana 15 mcg/2ml*

*Patient has a history of using at least 4 doses/day of albuterol or metaproterenol inhalation solution or at least 3 doses/day of a levalbuterol inhalation solution for 2 months or more as documented in the patient's medical record.

Diabetic Supplies

Test Strips Lancets Monitor
 Non-ins dependent Insulin dependent
 QTY _____ Patient tests _____ times a day

Enteral (including feeding kits & all related supplies)

Food: _____ Calories/day: _____
 Pump Syringe Gravity IV pole

Pulse Oximetry Services

Overnight oximetry Spot Check

X _____ / _____ / _____
 Physician's Handwritten Signature and Date

 Physician's Printed Name Address Phone

Phone: 937-629-0251 Toll Free: 1-800-892-4044 Fax: 937-629-0263
Store Hours: Monday - Friday 8 am - 5 pm

MEDICARE'S PULMONARY REQUIREMENTS

NEBULIZERS:

ICD-9 CODES 491.0 THRU 508.9

ASTHMA DXS MUST HAVE 5 DIGIT ICD-9 CODES

OXYGEN:

O2 SAT AT 88% OR BELOW AND/OR PO2 AT 55 OR BELOW

*IF PT QUALIFIES AT NIGHT, THEY MUST DROP TO 88% FOR AT LEAST 5 MINUTES

*IF PT QUALIFIES WITH EXERTION, THEY MUST ALSO BE TESTED ON ROOM AIR AT REST AND WITH EXERTION ON O2

*TEST DATE MUST BE WITH IN 30 DAYS OF OUTPATIENT OR WITH IN 48 HOURS OF DISCHARGE FROM AN INPATIENT STAY

COVERED DXS: Any respiratory related diagnosis, such as:

496	COPD
492	EMPHYSEMA
515	POST INFLAMMATORY PULMONARY FIBROSIS
486	PNEUMONIA
162.9	MALIGNANT NEOPLASM OF LUNG
511.9	PLEURAL EFFUSION
491.9	CHRONIC BRONCHITIS
493.2	CHRONIC OBSTRUCTIVE ASTHMA
799.02	HYPOXIA
428.0	CHF

CPAP:

AHI \geq 15 OR

AHI 5 TO 14 **WITH** EXCESSIVE DAYTIME SLEEPINESS,
IMPAIRED COGNITION, MOOD DISORDER,
INSOMNIA, HYPERTENSION, ISCHEMIC HEART
DISEASE OR HISTORY OF STROKE.

MEDICAID'S PULMONARY REQUIREMENTS

OXYGEN:

SAME AS MEDICARE

NEBULIZERS:

Icd-9 codes: 464, 466, or 480-519

ALL OTHER DXS REQUIRE PRIOR AUTHS FOR 1 - 3 MONTH RENTAL

CPAP:

SAME AS MCR EXCEPT THE TITRATION STUDY MUST BE AT LEAST 3 HOURS AND SHOWS A DECREASE IN AHI PLUS SHOW AN INCREASE IN O2 SAT OF AT LEAST 15%
OR AN INCREASE IN O2 SAT TO 89% OR **>** **OR** SHOWS OTHER CLINICAL IMPROVEMENT