Integrated HomeCare Services

CPAP • Oxygen • Mobility • Home Medical Equipment

HomeCare Equipment Order Form

Fax or Call for Orders:

Rockford:
Fax Order: (866) 511-5752
Call Us: (815) 227-0202
5027 Harrison Ave., Rockford IL 61108

Beloit:
Fax Order: (608) 312-2552
Call Us: (608) 313-0800
2020 Sutler Ave., Beloit, WI 53511

www.integratedhc.com

Order Date _____

Patient Information

Patient Name _____

Address _____

City _____ ST ____ ZIP _____

☐ Male ☐ Female

DOB _____

Height _____ Weight _____ lbs

Primary Phone # _____

Secondary Phone # _____

Diagnosis

ICD10 _____

_____

_____

Insurance Information

Primary insurance _____

Policy # _____ Group # _____

Secondary Insurance _____

Policy # _____ Group # _____

Prescribed Medical Equipment

- ☐ Semi-electric hospital bed
  - ☐ Full Rails ☐ Half Rails
- ☐ Standard Wheelchair
  - ☐ Wheelchair Cushion ☐ Lumbar Back Support
- ☐ Walker ☐ Walker w/ Wheels
- ☐ Trapeze Bar ☐ Lightweight Wheelchair
- ☐ Elevated Leg Rests ☐ Transfer Bench
- ☐ Cane ☐ Quad Cane
- ☐ Shower Chair ☐ 4 Wheel Walker w/ Seat
- ☐ Shower Chair w/ back
- ☐ Other

Length of need: _____

Prescriber Signature _____ Date _____

Physician Name _____

Address _____

_____

NPI # _____

Ordering Contact Name _____

Ordering Office Phone _____

By my signature, I authorize the use of this document as a dispensing prescription. I understand that the final decision with respect to ordering this (these) item(s) for this patient is a clinical decision made by me, based on the patient's clinical needs, and that my medical records support the medical need for the item(s) prescribed.

Please Note: *Additional requests for information and/or signature may be necessary to support proper billing for item(s)*