DOME HOME CARE
24 15TH STREET SUITE 205
BROOKLYN, NY 11215
(718) 854-5501
Provider # 4450490001

DURABLE MEDICAL EQUIPMENT STATEMENT OF ORDERING PHYSICIAN

Beneficiary Name: DOB: Effective Date:
Address: HICN:
City, State, Zip: **DATE LAST SEEN:** _____

DIAGNOSIS CODES: _____ _____ _____ _____ **HT:** **WT:**

HCPCS CODE	ITEM DESCRIPTION	QTY
B4034	ENTERAL FEEDING KITS, SYRINGE FD, PER DAY	30
A4320	IRRIGATION KIT W/ BULB SYRINGE	4
_____	***FORMULA**: _____	____
	***CALORIES PER DAY**: _____	
	Flow Rate: _____; **Hrs:**_____	
B4087	GASTROSTOMY FEEDING TUBE	1 (PER 3 MNTHS)
	TUBE TYPE/SIZE:	

THE ABOVE IS MEDICALLY NECESSARY BECAUSE:

Patient has: **(CIRCLE ONE & ADD APPLICABLE DX)**

(a) permanent (or at least 3 months)non-function or disease of the structures that normally permit food to reach the small bowel

ICD/10 CODE(S): _____ _____ _____ _____

(b) disease of the small bowel which impairs digestion and absorption of an oral diet,

ICD/10 CODE(S): _____ _____ _____ _____

Either of which requires tube feedings to provide sufficient nutrients to maintain weight and strength commensurate with the patient's overall health status.

PHYSICIAN NAME: UPIN:
ADDRESS: NPI#:
CITY, STATE, ZIP: NYS LIC:

_____ _____
PHYSICIAN SIGNATURE DATE

**** NOTE TO PHYSICIAN: BY SIGNING THIS DOCUMENT YOU ARE VERIFYING THERE IS SUPPORTING DOCUMENTATION IN PATIENTS PERMANENT MEDICAL RECORDS AND THIS DOCUMENTATION IS AVAILABLE UPON REQUEST.**