

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 ICD/10: _____ HT: _____ WT: _____

HCPCS CODE	ITEM DESCRIPTION	QTY
E0776	ENTERAL IV POLE	1
B4036	ENTERAL FEEDING BAGS, GRAVITY FD, PER DAY	30
A4320	IRRIGATION KIT W/PSTN OR BULB SYRINGE	15

_____ *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:
ADDRESS:
CITY, STATE, ZIP:

UPIN:
NPI#:
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.**