DOME HOME CARE
24 15TH STREET SUITE # 205
BROOKLYN, NY 11215
PHONE (718) 854-5501 FAX (718) 369-5858
Provider # 4450490001

DURABLE MEDICAL EQUIPMENT STATEMENT OF ORDERING PHYSICIAN

Beneficiary Name: Order Date:

Address: DOB:

DIAGNOSIS(ES)/ICD-10: _____ _____ _____Date last seen:_____

HCPCS CODE	ITEM DESCRIPTION	QTY
☐ B4087	GASTROSTOMY FEEDING TUBE SIZE: _____	1 (PER 3 MONTHS)

THE ABOVE IS MEDICALLY NECESSARY DUE TO:

(CIRCLE THE APPLICABLE REASON FOR REPLACEMENT)

1. IRRITATED SKIN, RASH AROUND THE TUBE; BURNING PAIN; FOUL ODOR; LOCAL INFECTION
2. LEAKING FROM THE TUBE ITSELF (HOLE IN THE TUBE), MALFUNCTIONING ANIT-REFLUX VALVE OR CAP) OR FORM AROUND THE FEEDING TUBE
3. NEED TO CHANGE DRESSING MORE THAN ONCE A DAY
4. FEEDING TUBE HAS BEEN DISLODGED
5. INSERTION HOLE SIZE CHANGED REQUIRING A DIFFERENT SIZE G-TUBE

I ESTIMATE THAT ITEM/S WILL BE NEEDED FOR:

NO. OF REFILLS:_____

PHYSICIAN NAME: NPI #:

_____ _____
PHYSICIAN SIGNATURE DATE

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

PLEASE ENCLOSE RELEVANT PROGRESS NOTES WITH REASON FOR REPLACEMENT WHEN RETURNING THE FORM