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: Effective Date:

Address: DOB:

City, State, Zip: HICN:

DIAGNOSIS(ES)/ICD-10: _____ _____ _____Prior Visit on:_____

HCPCS CODE	ITEM DESCRIPTION	QTY	
A4629	TRACH CARE KIT/ESTABLISHED TRACH	30	PER MONTH
A4623	TRACH DISPOSABLE INNER CANNULA	60	PER MONTH
	TRACH DIC SIZE: _____		
A7520-21	TRACH TUBE NON-CUFFED/CUFFED	1	PER 3 MONTHS
	TRACH TYPE AND SIZE: _____		
A7526	TRACHEOSTOMY TUBE COLLAR/HOLDER	30	PER MONTH

THE ABOVE IS MEDICALLY NECESSARY BECAUSE:

PATIENT HAS AN OPEN SURGICAL TRACHEOSTOMY AND IS EXPECTED TO REMAIN OPEN FOR AT LEAST 3 MONTHS.

I ESTIMATE THAT ITEM/S WILL BE NEEDED FOR:

NO. OF MONTHS:_____(99 = LIFETIME)

PHYSICIAN NAME: LIC #:

ADDRESS: NPI#:

CITY, STATE, ZIP:

_____ _____
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.**