DURABLE MEDICAL EQUIPMENT FORM

VIVA HEALTH, Inc.
417 20th Street North, Suite 1100
Birmingham, Alabama 35203
Phone: (205) 933-1201
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Check One: ☐ CERTIFICATION ☐ RECERTIFICATION

Check One: ☐ DME ☐ OXYGEN ☐ GLUCOMETER
☐ CPAP ☐ BIPAP

VIVA HEALTH USE ONLY
☐ Medicare
☐ Commercial
☐ VIVA MEDICARE *Me*

PATIENT INFORMATION

Complete all items pertaining to the patient's condition and equipment.

Patient Name:		Patient Member #:
Patient DOB:	Date Patient Last Seen by Doctor:	☐ Commercial ☐ MC ☐ ME
Diagnosis:	ICD-10 Code:	HPCS Code:

Estimated # of Months Equipment Needed: _____
(Do Not put "Indefinite"; be specific.)
Date Prescribed: _____

Rental Period This Certification Applies To:
(Certification length cannot exceed 12 months)

First Day (MM/DD/YYYY)	Last Day (MM/DD/YYYY)

Supplier's Name, Street Address, City, State, Zip Code, and Telephone Number:

Supplier's Tax ID:

Patient's Condition Concerning Mobility:

Bed confined? ☐ No ☐ Yes (complete below)
- ☐ 50% of the time
- ☐ 75% of the time
- ☐ 100% of the time

Room confined? ☐ No ☐ Yes

Wheelchair confined? ☐ No ☐ Yes

Ambulatory? ☐ No ☐ Yes (complete below)
- ☐ Assistance Not Required
- ☐ Assisted by a Walker or Cane
- ☐ Assisted by a Person

Is patient disoriented? ☐ No ☐ Yes

GENERAL EQUIPMENT

See the sections on the back of the form for oxygen and IPPB.

1. General Equipment Selected for Patient:
- ☐ a. Alternating P.P. & Pump (complete #4)
- ☐ b. Bed, Semi-Electric (complete #2 and #3)
- ☐ c. Bed, Standard
- ☐ d. Bed, Variable Height (complete #3)
- ☐ e. Cane or Quad Cane
- ☐ f. Walker ☐ With Wheels
- ☐ g. Wheelchair
  - ☐ i. Standard
  - ☐ ii. Electric (complete #5)
  - ☐ iii. Detachable Arms
  - ☐ iv. Leg Rests
  - ☐ v. Special; Type: _____
- ☐ h. Commode, Bedside
- ☐ i. Lift, Patient
- ☐ j. Nebulizer, Hand-Held
- ☐ k. Nebulizer, Ultrasonic
- ☐ l. Percussor
- ☐ m. Rails, Bedside
- ☐ n. Suction Machine
- ☐ o. Sitz Bath
- ☐ p. Traction Equipment
- ☐ q. Trapeze Bar
- ☐ r. Other; Describe: _____
  _____

COMPLETE WHEN INDICATED IN QUESTION 1 ON THE LEFT

2. Regarding electric beds, is the Patient able to work the controls and cause the adjustments? ☐ Yes ☐ No

3. Does the Patient's condition require frequent changed in body position not feasible in an ordinary bed? ☐ Yes ☐ No

4. Does the Patient now have or is the Patient susceptible to decubitus ulcers? ☐ Yes ☐ No

5. Attach the home evaluation and face-to face PT evaluation performed for electric wheelchair.

6. CPAP/BIPAP (attach sleep study report)
Date of sleep study: _____
Name of facility: _____
Respiratory disturbance index (RDI) pre-CPAP: _____
- ☐ CPAP pressures: _____
- ☐ BIPAP pressures: _____

7. If for recertification, has Patient demonstrated compliance in the use of this equipment? ☐ Yes ☐ No

Attach documentation.

SEE REVERSE SIDE FOR SIGNATURE

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OXYGEN *You must provide the lab results of the blood gas study (PO_2 or Oximetry) which you retain in your files. NOTE: You must also notify the carrier in writing when a Patient's condition or oxygen needs change.*

Report Date	PO_2 Level (MM of Hg)	Oximetry Level (% of O_2)	Where was test done?	Check condition of Patient during PO_2 or Oximetry Level test:	Was Patient on room air or oxygen at time of Blood Gas study?
			☐ Patient's Home ☐ Doctor's Office ☐ Nursing Home ☐ Independent Lab ☐ Hospital ☐ ASC	☐ During activities, such as exercise ☐ At rest ☐ While sleeping	☐ Room air ☐ Oxygen

Type Oxygen Unit Prescribed: ☐ Portable ☐ Stationary ☐ Concentrator

Type PO_2 Prescribed: ☐ Liquid ☐ Gaseous

How many hours per day is the Patient on Oxygen? _____hours

What is the flow rate in liters of O_2 per minute? _____liters O_2 /minute

IPPB

Diagnosis:	CPT:	ICD-10:

GLUCOMETER

Diagnosis:	CPT:	ICD-10:

Is the Patient's vision impaired enough to require a special glucose monitoring system at home? ☐ Yes ☐ No

Is the Patient capable of being trained to use a home blood glucose monitor? ☐ Yes ☐ No

If no, does Patient have a caregiver capable of being trained to use a home blood glucose monitor? ☐ Yes ☐ No

PHYSICIAN'S INFORMATION, CERTIFICATION, OR RECERTIFICATION – NOTICE: *This form must be completed, signed, and dated by the prescribing physician to accurately adjudicate the DME Claim. Any misrepresentation or falsification of information herein may constitute fraud and be subject to legal action.*

Physician's Name, Street Address, City, State, and ZIP Code:		Physician's Specialty:
Physician's Provider Number:	Office Fax Number:	Office Telephone Number:

I certify that I am actively treating this Patient, the equipment prescribed is part of my present course of treatment and is "reasonable and necessary" and is not prescribed as convenience equipment, plus all to the items completed on this form are accurate.

_____ _____

Attending Physician's Handwritten Signature (*stamped signature is NOT acceptable*) Date

REQUESTING COMPANY/PROVIDER INFORMATION

Requesting Company/Provider Name:	Requesting Company/Provider Fax Number: