care point MEDICAL
medical products. made easy.

General Product Referral Form

For Health & Managed Care Professionals

Fax fully completed form with Patient's signature to (866) 596-4447

PATIENT INFORMATION

Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Best time to contact patient: ☐ Morning ☐ Afternoon ☐ Evening Date of Birth ____/_____/_____

REQUIRED

PATIENT PERMISSION

•I am interested in learning more about CarePoint Medical home service program for the products indicated below. I authorize a representative from CarePoint to contact me.

•I authorize CarePoint Medical to contact my doctor as well as any Medicare, Medicare supplement, Medicaid or insurance for release of medical and other information in order to obtain products requested. My signature authorizes CarePoint Medical to submit a claim on my behalf and that assignment of Medicare, Medicare supplement, Medicaid or other insurance benefits for items obtained from CarePoint Medical be paid directly to CarePoint Medical.

_____ _____

Patient Signature Date

REFERRAL SOURCE

Contact Name _____

Organization _____

Phone _____ Date _____

PHYSICIAN INFORMATION *(optional)*

Name _____

Specialty _____

Phone _____

CAREPOINT MEDICAL PRODUCTS AVAILABLE

☐ Aqua Therapy Heating/Cooling Unit
☐ Back Supports
☐ Blood Pressure Monitor
☐ Cane
☐ Catheters
☐ Commode
☐ Compression Stockings
☐ Diabetic Shoes
☐ Diabetes Testing Supplies
☐ Erectile Dysfunction Vacuum Therapy
☐ Incontinence Products (check all that apply)
O Pads O Briefs O Pull Ons **Sizes:** O Small O Medium O Large O X-Large
O Underpads O Wipes O Creams
☐ Lymphadema Pneumatic Compression Home Therapy Unit
☐ Manual Wheel Chair/wheel chair seating
☐ Personal Emergency Response System (PERS)
☐ Seat Lift
☐ Support Surface Mattresses: O Gel Matt or O Alt. Air Matt
☐ TENS Unit/Neurapathy "Rebuilder" unit
☐ Therapeutic Wraps & Braces (check any that apply)
O Ankle O Foot O Knee O Wrist
O Hand O Shoulder O Elbow O Lumbar/Back
☐ Walker/Rollator
☐ Other _____

INSURANCE INFORMATION *(optional)*

☐ Medicare ☐ Medicaid ☐ Other _____

ID # _____ Group # _____ Phone _____

Policy Holders Name _____

Secondary Insurance _____

ID # _____ Group # _____ Phone _____

For more information, call CarePoint Medical Customer Care at (877) 4HM-HLTH (877-446-4584)
or visit www.carepointmedical.com

Certifying Statement Of Medical Need
Air Pressure Support

****** ALL MUST BE FILLED OUT BY PHYSICIAN ONLY!! ******

Patient Information

Name: _____

Address: _____

_____

_____

Phone: _____

D.O.B.: _____

Insurance: _____

Physician Information

NPI #: _____

Name: _____

Address: _____

_____

_____

Phone: _____

Fax: _____

PECOS Certified? _____ YES _____ NO

APPROVED SERVICES: E0181 - Group 1 Alternating Air Pressure Support Surface

SECTIONS 1&2 MUST BE COMPLETED FOR PRESCRIPTION TO BE VALID

1 DIAGNOSIS (*THIS MUST BE INDICATED***):**

A. Must indicate appropriate ICD-9 code: Diagnosis _____ Code _____

B. Must indicate patient's weight: _____

C. Indicate which of the following conditions apply to the patient. Check all that apply:

- ☐ Completely immobile-- i.e., patient cannot make changes in body position without assistance
- ☐ Limited mobility-- i.e., patient cannot independently make changes in body position significant enough to alleviate pressure OR any pressure ulcer on the trunk or pelvis

D. And which of the following secondary conditions apply to the patient, check all that apply:

- ☐ Imparied nutritional status Fecal or urinary incontinence
- ☐ Fecal or urinary incontinence
- ☐ Altered sensory perception Compromised circulatory status
- ☐ Compromised circulatory status

E. Duration of need in months is 99 = Lifetime, unless otherwise noted. _____

2 Signature - I certify that I have thoroughly documented the patient's medical necessity for the product(s) ordered within the patient's medical records and will provide all supporting documentation to CarePoint Medical, if requested.

Physician Signature:_____ **Date:**_____/_____/__2012__

******PHYSICIAN SIGNATURE AND PHYSICIAN INFORMATION MUST MATCH FOR PRESCRIPTION TO BE VALID******

SIGNATURE STAMPS ARE NOT ACCEPTABLE

Please fax prescription to: 804-747-8910

OR Scan & Email the prescription to: Rx@carepointmedical.com

CarePoint Medical
Fax: (866) 596-4447

4860 Cox Road, Suite 300, Glen Allen, VA 23060
customerservice@carepointmedical.com

Phone: (866) 596-4445
www.carepointmedical.com

Note: If any corrections to information, i.e., spelling, address, etc., are needed, please correct and initial.