Santa Clara Family Health Plan™

Durable Medical Equipment Order Form

A list of Durable Medical Equipment (DME) providers can be found using the Santa Clara Family Health Plan (SCFHP) Provider Search Tool at www.scfhp.com/for-members/find-a-doctor. Submit this order form directly to the DME provider using their submission contact information. DME orders must include clinical documentation such as physician visit notes, progress notes, etc. to support the DME items requested.

To request DME authorization, please use the SCFHP Prior Authorization Form found on the Provider Forms and Documents page on the SCFHP website.

Member Name: _____ Member ID:_____

Date of Birth: _____ Gender: _____

Address: _____ Phone Number: _____

_____

Plan: ☐ Medi-Cal ☐ Healthy Kids HMO ☐ Cal MediConnect

Diagnosis: _____ Diagnosis Code: _____

Height: _____ Weight: _____

Please check the DME being requested and offer details where appropriate.

☐ Wheel Chair	Months Needed: _____
☐ Standard Wheelchair (250 lbs Max) ☐ Heavy-Duty Wheelchair (Over 250 lbs) ☐ Wheelchair Cushion. Size: _____	☐ Detachable Arms ☐ Elevating Leg Rest ☐ Evaluation for Power Wheelchair and Power Wheelchair
☐ Hospital Bed	Months Needed: _____
☐ Semi-Electric ☐ Full Electric ☐ Half Side Rails ☐ Full Side Rails	☐ Over Head Trapeze ☐ Low Air Loss Mattress ☐ Alternating Pressure Pump and Pad (APP) ☐ Gel Mattress Overlay
☐ Assistive Device	Months Needed: _____
☐ Bedside Commode ☐ Front Wheeled Walker ☐ Crutches ☐ Quad Cane	☐ Single Point Cane ☐ Transfer Bench ☐ Sliding Board ☐ Raised Toilet Seat

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☐ Incontinence Supply	Months Needed: _____
☐ Diaper Size: _____ ☐ Underpad	☐ Number per month: _____
☐ Enteral Nutrition	Frequency Needed: _____
☐ Formula: _____ ☐ Feeding Tube ☐ NGT ☐ Gastrostomy ☐ Jejunostomy	☐ Administration ☐ Bolus ☐ Pump ☐ Daily Total: : _____Calorie/mL ☐ Syringe Size: _____ ☐ Water Flushing: _____
☐ Respiratory	Months Needed: _____
☐ Oxygen at _____ LPM Administration ☐ Nasal Cannula ☐ Mask System ☐ Concentrator ☐ E-Tanks	☐ CPAP Setting: _____ ☐ BIPAP Setting: _____ ☐ Nebulizer
☐ Other. Please Provide Details Below:	
_____ _____	

Additional Comments: _____

_____

Physician Name: _____ NPI: _____

Contact Name (if different from physician): _____

Address: _____ Phone Number: _____

_____

Physician's Signature: _____ Date: _____