KD HEALTHCARE SOLUTIONS, LLC

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General DME & Medical Supplies
Standard Written Order (SWO)

Patient Information

Patient Name | **DOB**

Address

City/State/ZIP

Phone | **Height** | **Weight**

Primary Plan | **Member ID**

Secondary Plan | **Member ID**

Medical Provider Information

Medical Provider | **NPI**

Phone | **Fax**

Diagnosis and Equipment / Supplies Ordered

ICD-10 Diagnosis(es)

Equipment / Supply Description

HCPCS (if known) | **Quantity** | **Frequency of Use**

Length of Need ☐ 3 Mo ☐ 6 Mo ☐ 12 Mo ☐ 99 Mo **Other**

Order Type ☐ Purchase ☐ Rental ☐ Repair ☐ Replacement ☐ Recurring Supplies ☐ Accessories

Clinical / Functional Medical Necessity (Check all that apply)

☐ Impaired mobility / ADLs
☐ Fall risk / safety concern
☐ Neurological impairment
☐ Weakness / impaired balance
☐ Caregiver assistance
☐ Home use required
☐ Wound / skin care need
☐ Diabetes management
☐ Respiratory care need
☐ Urological / incontinence
☐ Compression / vascular
Other

Clinical Comments Supporting Medical Necessity

I certify that the above equipment and/or supplies are medically necessary, reasonable and necessary for the treatment of this patient's condition, and supported by the patient's medical record.

Medical Provider Signature _____ **Date** _____

Printed Name _____ **Practice/ Facility Name** _____

Internal Use Only: Order ID _____ Date Received _____ Intake Initials _____ RN Approval _____