Referral Order Cover Page

Use this as the Cover Page when submitting orders to Prism Health Care

Today's date: ________________ Is Patient at Home? Yes or No Date of Discharge ________________

Attn: Intake Department Phone: 847-310-4730 *3

Email: orders@prismhc.com EFax: 872-469-1673

Referral Company/Agency:____

Your Name:__________________________ Contact#____________________

Contact E-Mail Address:__________________ Contact Fax:__________________

____

Patient Name:______________________________ DOB__________________

Equipment Ordered:____

Specific detail of the equipment and supplies ordered, i.e. size, height, width, type.

Will you be dispensing this equipment from your Consignment closet? **YES or NO**

We will be unable to process your request without the required documentation below.

Documentation Check List:

1. **Demographic Information**-Full Name, address, phone number, date of birth, height and weight, and contact information if other than patient.
2. **Insurance Information**-Insurance name, policy identification number, and group number.
3. **Dispensing Order**-A dispensing order to initiate order process.
4. **Medical record Noted**-Face to Face Encounter, PT notes, Progress notes, doctors or nurses notes, indicating the medical necessity for the equipment or supplies ordered.

*****Please note after review of the above documentation a Detailed Written Order will be forwarded to you and a Physician signature and date will be required before delivery*****

Thank you for your Order

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