Durable Medical Equipment (DME) Request/Referral Form

161 River Road, Unit 1
Bow, NH 03304

Tel: 603.225.0180

Mon-Fri 8am – 4pm

Insurance Referral Fax: 855.543.3645

Please fax this completed form along with a patient demographic sheet, a physician face-to-face (if available) and associated progress notes to Renmar DME.

PATIENT INFORMATION				
First Name:	Last Name:	M.I.	Phone:	
Address:	City:	State:	Zip:	
DOB:	Gender:	Ht:	Wt:	Social Security #:
Emergency Contact/Resp Party:			Phone:	
Address:	Email:			
INSURANCE INFORMATION				
Primary Ins: ☐ Medicare ☐ Medicaid ☐ Other	Secondary Ins: ☐ Medicare ☐ Medicaid ☐ Other			
Name:	Name:			
Member ID #:	Member ID #:			
DIAGNOSES / ICD-10 CODES				
Dx 1:	Dx 2:	Dx 3:	Dx 4:	
EQUIPMENT NEEDED: (Check Items)				
☐ Power Wheelchair	☐ Lift Recliner	☐ Repairs		
☐ Manual Wheelchair	☐ Hand Splint			
☐ Wheelchair Cushion	☐ Power Scooters	☐ Other		
PHYSICIAN INFORMATION				
Name:	NPI#:			
Address:	City:	State:	Zip:	
Physician Office Contact:	Phone:	Fax:		

Referral From: _____ **Contact Phone:** _____
(First Name, Last Name)

Organization_____
(If applicable)