

DW MEDICAL SUPPLY ,INC  
1524 Centinela Ave  
Inglewood CA 90302

**(310) 330-0162 \* Fax (310) 330-0199**

**Detailed Written Order**

Medicare regulations mandate that all of the following elements be included on the prescription/written order for a Hospital Bed. Also, please provide any chart notes that relate to the equipment being ordered.

Beneficiary Name: \_\_\_\_\_

Medicare Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Description of the item ordered:**

Semi-Electric Hospital Bed with Mattress

Heavy Duty Hospital Bed with Mattress

**Accessories needed for hospital bed that has been ordered:**

Please choose the type of rails to be included with the bed

**Full                  Half                  None**

Please indicate if you would like a Trapeze bar include with the bed

**Trapeze Bar:        Yes                  No**

Date of completion of the last face-to-face examination if applicable: \_\_\_\_\_

Pertinent diagnoses/conditions that relate to the need for the item or items ordered:  
\_\_\_\_\_  
\_\_\_\_\_

Length of need in months: (99 = lifetime) \_\_\_\_\_

Physician's Name: \_\_\_\_\_ NPI # \_\_\_\_\_

Physician's signature: \_\_\_\_\_ Date: \_\_\_\_\_