



Care Wisconsin Supply Order

To ensure quality and order fulfillment in a timely manner please fill in all fields. PCP/NP signature line at end of form, please sign when submitting

Care Wisconsin Member Name (First & Last): _____ Today's Date: _____

Care Wisconsin Member Phone Number for Resupply Phone Call (inform the member they will receive an automated resupply phone call before their monthly order): _____

Address: _____ Apt/Unit: _____ City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Gender: Male Female Other Member Height: _____ ft. _____ in. Member Weight: _____ lbs.

Medicaid Policy #: _____ Medicare Policy #: _____ Product (if known) Family Care Partnership SSI Dual Advantage

Additional Insurance Information: Name: _____ Policy#: _____

Is the Member being seen by a Home Health Agency? Yes No Agency Name: _____

Agency Phone #: _____ Agency Care Provider Name (First & Last): _____

Physician Name (First & Last if known): _____ Phone #: _____ NPI Number (if known): _____

Supply Order Duration: 30 Days 90 Days 365 Days Full Episode Other _____

LIGHTWEIGHT DURABLE MEDICAL EQUIPMENT (DME):			
PLEASE SPECIFY PRIMARY DIAGNOSIS:			
Standard offset adjustable cane 300 lb. cap (E0100)	_____	Each	_____
Bariatric offset adjustable cane 500 lb. cap (E0100)	_____	Each	_____
Small base adjustable quad cane 300 lb. cap (E0105)	_____	Each	_____
Large base adjustable quad cane 500 lb. cap (E0105)	_____	Each	_____
Sidestepper cane 250 lb. cap (E0135)	_____	Each	_____
Adult walker (E0143) with wheels <input type="checkbox"/>	_____	Each	_____
Heavy duty walker with wheels 500 lb. capacity, adjustable to 39" (E0148)	_____	Each	_____
Adult walker (Rollator) with brakes and wheels (E0143)	_____	Each	_____
Adult wheelchair 300 lb. cap (K0001): 16" <input type="checkbox"/> 18" <input type="checkbox"/> 20" <input type="checkbox"/>	_____	Each	_____
2" wheelchair gel cushion (E2601): 16" <input type="checkbox"/> 18" <input type="checkbox"/> 20" <input type="checkbox"/>	_____	Each	_____
Handheld shower	_____	Each	_____
Therapeutic TENS unit (E0730)	_____	Each	_____
Adult forearm crutch (E0110)	_____	Each	_____
Adult crutch 300 lb. cap. (E0114)	_____	Pair	_____
Adult bariatric crutch 650 lb. cap (E0114)	_____	Pair	_____
Adult knee walker 300 lb. cap. (E0118)	_____	Each	_____
Bedside drop arm commode chair 350 lb. cap. (E0163)	_____	Each	_____
Padded bedside drop arm commode chair 350 lb. cap. (E0165)	_____	Each	_____
Heavy duty 650 lb. cap. Drop arm commode chair (E0168)	_____	Each	_____
Shower chair 250 lb. cap. (E0240)	_____	Each	_____
Elevated toilet seat (E0244) with arms <input type="checkbox"/> without arms <input type="checkbox"/>	_____	Each	_____
Bath bench (E0245) with back <input type="checkbox"/> without back <input type="checkbox"/>	_____	Each	_____
Transfer bench (E0247) padded <input type="checkbox"/> un padded <input type="checkbox"/>	_____	Each	_____
Heavy duty transfer bench with commode opening 550 lb. cap. (E0248)	_____	Each	_____
Notes / Other: _____			
ENTERAL FEEDING SUPPLIES (DMS) CHECK PRIMARY DIAGNOSIS:			
<input type="checkbox"/> R68.69 OTHER GENERAL SYMPTOMS AND SIGNS <input type="checkbox"/> R32 UNSPECIFIED URINARY INCONTINANCE <input type="checkbox"/> E63.9 NUTRITIONAL DEFICIENCIES, UNSPECIFIED <input type="checkbox"/> R63.3 FEEDING DIFFICULTIES <input type="checkbox"/> E63.8 OTHER NUTRITIONAL DEFICIENCIES <input type="checkbox"/> OTHER: _____			
B4100 Oral Food Thickener: QTY: _____	Powder (oz.): 10 36 64 Gel (gm.): 15 30	Units: _____ /day	Units: _____ /month
B4102 Enteral Electrolyte Formula 500 ML = 1 UNIT	Ensure: Wild Berry Mixed Fruit Apple	Units: _____ /day	Units: _____ /month
B4104 Fiber Additive for Enterals	Fiber powder: 7.2oz. Qty: _____	Units: _____ /day	Units: _____ /month
B4150 Enteral Formula 100 CALORIES = 1 UNIT	Boost <input type="checkbox"/> Ensure <input type="checkbox"/>	Units: _____ /day	Units: _____ /month
Hi Protein: <input type="checkbox"/>	Chocolate <input type="checkbox"/> Vanilla <input type="checkbox"/> Strawberry <input type="checkbox"/> Butter Pecan <input type="checkbox"/>	Units: _____ /day	Units: _____ /month
	Jevity 1.0 <input type="checkbox"/> Jevity 1.2 <input type="checkbox"/> Osmolite 1.0 <input type="checkbox"/>	Units: _____ /day	Units: _____ /month
B4152 Enteral Formula Greater Than 1.5 KCAL/ML 100 CALORIES = 1 UNIT	Boost Plus <input type="checkbox"/> Ensure Plus <input type="checkbox"/>	Units: _____ /day	Units: _____ /month
	Chocolate <input type="checkbox"/> Vanilla <input type="checkbox"/> Strawberry <input type="checkbox"/> Butter Pecan <input type="checkbox"/>	Units: _____ /day	Units: _____ /month
B4034 Enteral Feeding Kit (includes bag, 60 CC syringe)	Units: _____ /day	Units: _____ /month	
B4035 Enteral Feeding Pump Kit (includes 1000 ML bag, tips)	Kangaroo: E set <input type="checkbox"/> Joey set <input type="checkbox"/> Sets: _____ /month		
Notes / Other: _____			
B4154 Enteral Formula for Special Metabolic Needs 100 CALORIES = 1 UNIT		Units: _____ /day	Units: _____ /month
		BOOST Glucose Control <input type="checkbox"/>	
		Chocolate <input type="checkbox"/> Vanilla <input type="checkbox"/> Strawberry <input type="checkbox"/>	
		Glucerna: 1.0 <input type="checkbox"/> 1.2 <input type="checkbox"/> Shake <input type="checkbox"/>	
		Chocolate <input type="checkbox"/> Vanilla <input type="checkbox"/> Strawberry <input type="checkbox"/> Butter Pecan <input type="checkbox"/>	
		Nepro: Vanilla <input type="checkbox"/> Mixed Berry <input type="checkbox"/> Butter Pecan <input type="checkbox"/>	
		Resource Breeze: Peach <input type="checkbox"/> Variety <input type="checkbox"/> Orange <input type="checkbox"/>	
B4155 Nutritionally Incomplete Enteral Formula 100 CALORIES = 1 UNIT		Units: _____ /day	Units: _____ /month
		Orange <input type="checkbox"/> Cherry <input type="checkbox"/> Fruit Punch <input type="checkbox"/> Unflavored <input type="checkbox"/>	
B4160 Enteral Formula for Pediatrics 100 CALORIES = 1UNIT		Units: _____ /day	Units: _____ /month
		Boost: <input type="checkbox"/> Pediasure: <input type="checkbox"/> 1.0 <input type="checkbox"/> 1.5 <input type="checkbox"/> 1.5 w/fiber <input type="checkbox"/>	
		Chocolate <input type="checkbox"/> Vanilla <input type="checkbox"/> Strawberry <input type="checkbox"/>	
B4036 Enteral Feeding Gravity Kit (includes 1000 ML bag, tips)		Sets: _____ /month	

Printed name of Prescribing Physician, Registered Nurse or Nurse Practitioner: _____

Signature of Prescribing Physician, Registered Nurse or Nurse Practitioner: _____

Date: _____

Have Questions or need to sample product first? Call the Dedicated Team: 888-532-8830

Send Complete Forms to: Fax: 866-202-1563 Email: Managedcarefax@medline.com