My Choice 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

My Choice Wisconsin Member Name (First & Last):______________________ **Today's Date:** ____________

My Choice 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:** ______________ **Sate:** ________ **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 ______________

PRODUCTS

LIGHTWEIGHT DURABLE MEDICAL EQUIPMENT (DME):

PLEASE SPECIFY PRIMARY DIAGNOSIS:______________

Item	Qty	Item	Qty
Standard offset adjustable cane 300 lb. cap (E0100)	________Each	Adult forearm crutch (E0110)	________Each
Bariatric offset adjustable cane 500 lb. cap (E0100)	________Each	Adult crutch 300 lb. cap. (E0114)	________Pair
Small base adjustable quad cane 300 lb. cap (E0105)	________Each	Adult bariatric crutch 650 lb. cap (E0114)	________Pair
Large base adjustable quad cane 500 lb. cap (E0105)	________Each	Adult knee walker 300 lb. cap. (E0118)	________Each
Sidestepper cane 250 lb. cap (E0135)	________Each	Bedside drop arm commode chair 350 lb. cap. (E0163)	________Each
Adult walker (E0143) with wheels ☐	________Each	Padded bedside drop arm commode chair 350 lb. cap. (E0165)	________Each
Heavy duty walker with wheels 500 lb. capacity, adjustable to 39" (E0148)	________Each	Heavy duty 650 lb. cap. Drop arm commode chair (E0168)	________Each
Adult walker (Rollator) with brakes and wheels (E0143)	________Each	Shower chair 250 lb. cap. (E0240)	________Each
Adult wheelchair 300 lb. cap (K0001): 16" ☐ 18" ☐ 20" ☐	________Each	Elevated toilet seat (E0244) with arms ☐ without arms ☐	________Each
2" wheelchair gel cushion (E2601): 16" ☐ 18" ☐ 20" ☐	________Each	Bath bench (E0245) with back ☐ without back ☐	________Each
Handheld shower	________Each	Transfer bench (E0247) padded ☐ un padded ☐	________Each
Therapeutic TENS unit (E0730)	________Each	Heavy duty transfer bench with commode opening 550 lb. cap. (E0248)	________Each

Notes / Other:

ENTERAL FEEDING SUPPLIES (DMS) CHECK PRIMARY DIAGNOSIS:

☐ R68.69 OTHER GENERAL SYMPTOMS AND SIGNS ☐ R32 UNSPECIFIED URINARY INCONTINANCE ☐ E63.9 NUTRITIONAL DEFICIENCIES, UNSPECIFIED
☐ R63.3 FEEDING DIFFICULTES ☐ E63.8 OTHER NUTRITIONAL DEFICIENCIES ☐ OTHER:______________

Item	Details	Item	Details
B4100 Oral Food Thickener: QTY:_____	Powder (oz.): 10 36 64 Gel (gm.): 15 30	**B4154 Enteral Formula for Special Metabolic Needs 100 CALORIES = 1 UNIT**	Units: _______ /day Units:_______ /month
B4102 Enteral Electrolyte Formula 500 ML= 1 UNIT	Units: _______ /day Units:_______ /month		**BOOST** Glucose Control ☐
	Ensure: Wild Berry Mixed Fruit Apple		Chocolate ☐ Vanilla ☐ Strawberry ☐
B4104 Fiber Additive for Enterals	Fiber powder: 7.2oz. Qty:______		**Glucerna**: 1.0 ☐ 1.2 ☐ Shake ☐
B4150 Enteral Formula 100 CALORIES = 1 UNIT	Units: _______ /day Units:_______ /month		Chocolate ☐ Vanilla ☐ Strawberry ☐ Butter Pecan ☐
	Boost ☐ **Ensure** ☐		**Nepro**: Vanilla ☐ Mixed Berry ☐ Butter Pecan ☐
Hi Protein: ☐	Chocolate ☐ Vanilla ☐ Strawberry ☐ Butter Pecan ☐		**Resource Breeze**: Peach ☐ Variety ☐ Orange ☐
	Jevity 1.0 ☐ **Jevity 1.2** ☐ **Osmolite 1.0** ☐	**B4155 Nutritionally Incomplete Enteral Formula 100 CALORIES = 1 UNIT**	Units: _______ /day Units:_______ /month
B4152 Enteral Formula Greater Than 1.5 KCAL/ML 100 CALORIES = 1 UNIT	Units: _______ /day Units:_______ /month		Orange ☐ Cherry ☐ Fruit Punch ☐ Unflavored ☐
	Boost Plus ☐ **Ensure Plus** ☐	**B4160 Enteral Formula for Pediatrics 100 CALORIES = 1UNIT**	Units: _______ /day Units:_______ /month
	Chocolate ☐ Vanilla ☐ Strawberry ☐ Butter Pecan ☐		**Boost:** ☐ **Pediasure:** ☐ 1.0 ☐ 1.5 ☐ 1.5 w/fiber ☐
B4034 Enteral Feeding Kit (includes bag, 60 CC syringe)	Units: _______ /day Units:_______ /month		Chocolate ☐ Vanilla ☐ Strawberry ☐
B4035 Enteral Feeding Pump Kit (includes 1000 ML bag, tips)	Kangaroo: E set ☐ Joey set ☐ Sets:_______ /month	**B4036 Enteral Feeding Gravity Kit (includes 1000 ML bag, tips)**	Sets:_______ /month

Notes / Other:

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