

# DME Case Form

Date: \_\_\_/\_\_\_/\_\_\_ Case Taken by: \_\_\_\_\_ Case in System: Yes or No  
 Time: \_\_\_:\_\_\_ (circle one)

Called in By:  CM  ADJ  Provider  Claimant  Lawyer

Called in by Other: \_\_\_\_\_ Case Assign to: \_\_\_\_\_ By: \_\_\_\_\_

## Client Information

Client Billing Info (Name of Insurance Carrier): \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Ext: \_\_\_\_\_ Fax #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 Email Address: \_\_\_\_\_

## Adjusters Information

Adj Name: \_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 Company: \_\_\_\_\_ Email: \_\_\_\_\_

## Case Manager Information

CM Name: \_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 Company: \_\_\_\_\_ Email: \_\_\_\_\_

**Contact:** Adjuster Or Case Manager      **Prescription:** Yes or No

## Claimant Information

Apartment  House

Claimants Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ D.O.B. \_\_\_/\_\_\_/\_\_\_

Delivery Address (*if not the same as physical address*) \_\_\_\_\_

## Claim Information

Claim #: \_\_\_\_\_ SS #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_  
 Type of Injury: \_\_\_\_\_ Date of Injury: \_\_\_/\_\_\_/\_\_\_  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Doctors Name: _____	Employer: _____
Doctor's #: _____	
Doctor's UPIN#: _____	Employer #: _____

## ***Medical Supply - Durable Medical Equipment - Other Supply***

Qty	Item Ordered	Item#	HCPC	Cost	LTD	MSRP