InTandem DME Referral & Order Form

InTandem Support: 855-900-7837
Fax: 636-565-1111
Secure Upload: intandemrx.com/upload

intandem® By MedRhythms
www.intandemrx.com

Patient Authorization

For the patient to complete.

By signing below, I authorize the sharing of my health information with InTandem Support and consent to be contacted by phone call, voicemail, text message, and/or email, directly or through the person listed under "Primary Contact". I also confirm that I have read the Program Certifications & Authorizations (see www.intandemrx.com/terms or following pages).

Patient or Legal Representative* Signature _____

Patient Printed Name _____ Date (MM/DD/YYYY) _____

Primary Contact

For the patient, legal representative, or referring provider to complete.

First Name _____ Middle Name _____ Last Name _____

Street Address _____

City _____ State _____ Zip Code _____

Phone Number _____ Email _____

Order Information

For the referring provider to complete.

Patient First Name _____ Patient Last Name _____ Patient DOB _____

Length of Need for InTandem (HCPCS-code E3200)

- ☐ 3 Months
- ☐ 6 Months
- ☐ 99 Months (Lifetime)
- ☐ Other Duration _____

Diagnosis Code (ICD-10)

Stroke Codes

- ☐ I63.9
- ☐ I69.3
- ☐ I69.354
- ☐ I61.9
- ☐ I69.351
- ☐ I69.359
- ☐ _____

Gait Impairment Codes

- ☐ R26.89
- ☐ Z74.09
- ☐ R26.81
- ☐ R26.9
- ☐ _____

Comments _____

Referring Provider

For the referring provider to complete.

First Name _____ Last Name _____ NPI # _____

Practice Name _____ Phone _____

If patient has not signed above:

☐ By checking at left, I confirm that I have the patient's written consent to release to MedRhythms and its representatives, agents, and contractors his or her protected health information ("PHI"), including but not limited to my patient's name, medical records, information relating to his or her medical condition, treatment, and health insurance, as well as all information provided on my prescription for purposes of providing the services offered by InTandem support, including without limitation, financial support services, providing product support, communication and exchange PHI with my patient's health care providers, pharmacies or medical equipment suppliers, and health insurers for reasons related to the program, and contacting my patient by mail, email, text, or telephone (including voicemail).

By signing below, I certify that I am referring the above patient for InTandem. This therapy is a part of the patient's treatment plan, and is medically necessary for their continued rehabilitation:

Referring Provider Signature _____ Date _____

Prescriber Authorization

For the ordering prescriber to complete.

First Name _____ Last Name _____ NPI # _____

Street Address _____

City _____ State _____ Zip Code _____

Phone Number _____ Fax Number _____

Email _____

This document serves as a Standard Written Order and Prescription for InTandem [UDI: (01)00860001790801] for this patient. As this patient's physician, I attest that the clinical findings on this document accurately reflect the health information. I certify that InTandem is reasonable and medically necessary for the treatment of this patient.

Prescriber Signature _____ Date _____

*By signing on behalf of the patient, as representative or guardian, you attest that you are legally able to sign such documents on the patient's behalf and are properly acting in your capacity doing so. Proof of such guardian's or representative's authority to act for the patient may be requested such as power of attorney or legal court order.