MAJOR AND MINOR EQUIPMENT LIST

Please note the(*) items indicates High Cost Items that require Certificates of Medical Necessity (CMNs) to be completed by the Physician. (See Attachment B for sample CMN)

MAJOR EQUIPMENT ITEMS	COST
* Hospital Beds	*
*Air-Fluidized Beds (e.g., Support Surfaces)	*
* Wheelchairs	* $550-$1,800
*Power Operated Vehicles (POVs)	* $4,000- $12,000
* Specialized Cushions for wheelchairs (e.g., ROHO, JAY)	* $250- $300
* Seat Lift Mechanisms	*
*Continuous Positive Airway Pressure (CPAP) devices	*
*Oxygen	*
* Lymphedema Pumps	*
* Osteogenesis Stimulators	*
* Transcutaneous Electrical Nerve Stimulators (TENS)	*
* **Infusion Pumps**	*
* **Parenteral Nutrition**	*
* Enteral Nutrition	*
• Ankle Foot Orthosis (AFO)	$500+
• Knee Ankle Foot Orthosis (KAFO)	$1,300+
• Reciprocating Gait Orthosis (RGO) or (HKAFO)	$3,000+
• Prosthetics	$10,000+
• Helmets	$121
• **Custom Compression Pressure Gannents**	$142+
• Soft Quad Body Jackets	$240+
• Hard-shell Body Jackets	$980+
• Dynamic wrist Action or Driven Wrist Hand Orthosis (WHO)	$1,300+
• Rachel flexor hinge hand splints	$1,000
• Gunslinger	$1,100

MAJOR AND MINOR EQUIPMENT LIST

Item	Cost
• Hearing Aids	$450 - $3,000
• **Electronic Communication Devices**	$50- $3,000
• Electrolarynx	$150-$350

MAJOR AND MINOR EQUIPMENT LIST

MINOR EQUIPMENT ITEMS	COST
• Axillary Crutches	$40
• **Foreann Crutches**	$121
• **Canes**	over $25
• Shower Chairs	$38-456,$125 for padded
• **Toilet seat raiser**	$89
• Toilet seat safety fram	$50- $69
• Mobil Arm Support	$360
• Overbed Table	$200
• Anti-embolism Stockings	$10+
• Cane	$25
• **Crutch Accessories**	Under $20
• Foam Cushions under $25	$25
• Grab Bars	$20
• Sliding Boards	$30
• Sacral Back Pads	$20
• Jay Solid Seat Insert	$21
• Prefabricated wrist supports	Over$25
• Lap Tray Under $50	$50
• Knee Spreader with Mirror	$27
• Writing Aid	Over $25
• Push Cuffs	$28+
• Knee Spreader with Mirror	$27
• Minor ADL Equipments e.g., Bath Brush, Suction Denture Brush, Shampoo Tray, Utensil holder etc.	$3- $28

DURABLE MEDICAL EQUIPMENT PRESCRIPTION

,Medical #--::-----------
Medicare#--------------------------
Other Insurance______________

Issue Date
Effective Date -------
Member#----------------------

Date Written______________

Patient's Name (please print) | Current Address | Current Phone#

Diagnosis: ______ Onset:

Prognosis: [ ] Permanent Disability [J ______ Other

Reasons **for Referral:** (please mark boxes)

Ambulatory Eguiqment:
[ ] cane [ ] axillary crutches
[]walker [ ] forearm crutches

Bath Eguiqment:
[] bench [] padded []unpadded
[ ] raised toilet seat__________ inches
[ ] other: ______________

Wheelchair ReQairs:
New Upholstery: [ ] seat
[ ] back

Wheel Locks: [ ] replace
[1 repair

Footrest(s): [ ] replace
[ ] repair

New Caster Wheels [J
New Rear Tires [I

Arm Rest(s): [] replace
[J repair

[ ] New Arm Rest Pads
[ ] New Batteries
[ ] R"'pair Electronics

Cushion: [ ) pressure relieving
[lCl)'!tlfort cushion

.] Reachers

[ ] Other: ____

Medical Necessiry: Patient is
[I Unsafe walking without aids.
[J Unsafe bathing/toileting without aids.
[I Non-ambulatory and depends on wheelchair for independent mobllity.
[ ] Limited ambulator with equipment: ______________
[I Patient sits more than 4 hours each day.

[I The wheelchair needs to be in good working condition to prevent injuries and assure appropriate level of independence.

Physician Signature | UPIN # | Physician's License#

Therapist/Health Care Provider | Area | Extension#

omdor | City

W/C brand, model, serial # | Year Purchased

Name:

Rancho #:

Birth Date:

I.P. Unit | O.P. Cl #:

Attachment C

owr\ty of Los Angeles RANCHO LOS AMIGOS NATIONAL REHABILITATION CENTER Department of Health Services

EASE PRINT EXCEPT WHERE NOTED

ORTHOTIC PRESCRIPTION

Orthotic Cont.#_____________

f'S NAME ═,-------'---═,--------'-----;;-, RLAMC # ———— Unit/Clinic----------
LAST FIRST INT.

adress NUMBER STREET ;:cm;;w;----------- CITY -----------,rn-;.-- STATE ZIP CODE Phone: L----'---------

Ig n os i:s:=:=:=:=:=:=:=:=:=:=:=:=:=:= S er vi ce =========================:: Date________________

PRESCRIPTION:

Birth Date________________

Onset Date----------

Soc. Sec.#________________

Admit Date________________

Disch. Date________________

DELIVER TO:

D Treatment area:____________

o Patient

Prescribed by:__________________,=====,------ M.D. Lie.#--------! -----...===== ---
PHYSICIAN'S SIGNATURE PR!.NT THERAPIST'S NAME

'Physician's Name__________________________________--l Phone Ext.-----------

EDICALJUSTIFICATION:____

(ABOVE TO BE COMPLETED BY PHYSICIAN OR THERAPIST)

1te Delivered________________ Received by Date

MEDICAL COVERAGE

INSURANCE

lling Code----- -------

1 Medi-Cal#________________

I Medicare# ————————————

1 Medicare/Medi-Cal

J CCS#________________

]MDA #---- -------------

Ins. Co. Name________________________________

Group#________________ Cert. #________________

Address________________________________

Phone: (__--'L---------------------------

Insured's Name ——————————————————————————

Coverage________________________________

1 nth e r:=:=:=:=:=:=:=:=:=:=:==--_:-S ec:o nd a ry In=s. ==

COUNTY AUTHORIZATION STAMP

EQIJIPMENT/SUPPLY EXEMPTION REQUEST
For Patients with No Third Party Payor

TO BE COMPLETED BY THE PERSON WHO WRITES THE PRESCRIPTION:

The patient named below has no third pany payor or alternative funding resources. I, tberefore, recommend that Rancho Los Amigos Medical Center allocate/purchase tbe prescribed equipmerulsupply.

Patient Name:________________ RLA#________________

Patient's Address________________ Patient's Telephone#:________________

Clinic Name:________________ Diagnosis:________________

Treating Therapist:________________ EXT.________________

Attending Physidan:________________ Ext.________________

EquipmentJSupply Prescribed:________________ Estimated Cost________________

This is a request for major equipment: ☐ Yes ☐ No

If eqnipment can be purchased from a vendor witb alternative resources, indicate patiem' s vendor chorioe, including address, & phone number: ________________

SOCIAL WORK OFFICE:

Recommended By:________________ (Social Worker Signature) Ext.________ D :________

REQUIRED FOR MAJOR EQUIPMENT ONLY:

Autborized By:________________ Physician's Signature Ext.________ D e:________

REFERRED TO ☐ Seating Cemer ☐ Central Supplies ☐ Pool Stock Oomer________________-c-

---

ISSUING DEPARTMENT NAME: ________________

Orssued from Invemory ☐ Prepared HS-2 ☐ Other ___ Equip. Cost ☐

Social Work notified onoe order for major equipment is processed & equipment *is* received? ☐ ______

FOR CMO OFFICE ONLY De Received: ________

COMMENTS: ________________

Copies: 1) Attach to prescription; 2) Originating Area; 3) Social Work Department; 4) Chief Medical Officer

KANLHU LOS AMIGUS I'UUNDATION

Policy No. 508
Attachment E ·

AMIGOS FUND

CHECK REQUEST tORM

Amount of Request: $_________________ TODAY'SDATE:._________________

Department/Area Requesting Funds:____

Source of Funds: General _Designated Fund (name)____________,_______Other__________

Specific Description of Item (inducting name and address of Payee). — — — — — — — — — — — — — —

____

____

Justification: (Use separate sheet if necessary, indude patienr(s) name if not provided with attachments)

____

____

MAKE CHECK PAYABLE TO-------------------- ----

REQUESTEDBY=-- --- ----- APPROVEDBY_______________ —
(Signature} (Dept. Head/Svs. Chief- Signature Required)

APPROVED BY HOSPITAL ADMINISTRATION-DIRECTOR OF PROFESSIONAL SERVICES (If request Is over $500.00, signature Is required) ·

DISPOSITION:

) MAIL or ( ) HOLD FOR PICK-UP· CALL.____________________________ EXT___________

* * * *"*********** ***************FOUNDATION USE ONLY****·**********************

____Approved

____Disapproved

O – ______ _____ ________
President/Vice President Signature Date

CHECK#_______________CHECK DATE___________ G/L#------------

CHECK RECEIVED BY/MAILED:._-=---------- /----,,---------
Signaturee Date

SUBMIT ALL FUND REQUESTS TO:. RLA FOUNDATION, BLDG..601
FOR INFORMATION CONTACT: FOUNDATION OFFICE- X7053

C cu..Eq