REFERRAL FORM

This complete form must be sent to Express Durable Medical Equipment LLC
via fax **(651) 493-6892** or e-mailed as an attachment to
SUPPORT@EXPRESSDME.NET

NPI: 1730504143

Referral Contact Person:_____

Phone: _____ OR **E-mail:** _____

CLIENT INFORMATION

First Name:_____ Last Name: _____

Address: _____

City: _____State:_____ Zip:_____

DOB: _____

Phone/Contact Number: _____

Client Ins & Ins ID# _____ _____

PHYSICIAN INFORMATION

Practice Name: _____

Physician Name: _____

NPI #: _____

Phone Number: _____ Fax Number: _____

PRESCRIPTION

Diagnosis Code: _____

Diagnosis Description: _____

Start Date of Order: _____

Description of Item(s) : _____

_____

_____

_____

Special instructions & Details:

_____

_____

_____

EXPRESS
MEDICAL EQUIPMENT

2200 HWY 36 EAST STE 2206, SAINT PAUL, MN 55109

PHONE: (651) 493-7348 // FAX: (651) 493-6892

WWW.EXPRESSDME.ORG