DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved OMB
No. 0938-0679
Expires xx/2020

DME 09.03

DME INFORMATION FORM
CMS-10125 — EXTERNAL INFUSION PUMPS

Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___ RECERTIFICATION___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and Medicare ID		SUPPLIER NAME, ADDRESS, TELEPHONE and NSC or NPI #
(__ __ __) __ __ __ - __ __ __ __ Medicare ID _____		(__ __ __) __ __ __ - __ __ __ __ NSC or NPI #_____
PLACE OF SERVICE _____	SUPPLY ITEM/SERVICE PROCEDURE CODE(S):	PT DOB ____/____/____ Sex ____ (M/F) Ht. ____(in) Wt ____(lbs.)
NAME and ADDRESS of FACILITY *if applicable (see reverse)*	_____ _____ _____ _____	PHYSICIAN NAME, ADDRESS, TELEPHONE and UPIN or NPI # (__ __ __) __ __ __ - __ __ __ __ UPIN or NPI #_____
ANSWERS		ANSWER QUESTIONS 1–4 FOR EXTERNAL INFUSION PUMP.
SUPPLY ITEM/SERVICE PROCEDURE CODE(S): a) _____ b) _____ c) _____		1. Provide the Supply Item/Service Procedure code(s) for the drug(s) that requires the use of the pump.
a) _____ b) _____ c) _____		2. If a NOC (not otherwise classified) Supply Item/Service Procedure code is listed in question 1, print name of drug.
❑ 1 ❑ 2 ❑ 3 ❑ 4		3. Check number for route of administration? 1 – Intravenous 2 – Subcutaneous 3 – Epidural 4 – Other
❑ 1 ❑ 2		4. Check number for method of administration? 1 – Continuous 2 – Intermittent

Supplier Attestation and Signature/Date

I certify that I am the supplier identified on this DME Information Form and that the information provided is true, accurate, and complete, to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact associated with billing this service may subject me to civil or criminal liability.

SUPPLIER SIGNATURE_____ DATE _____/_____/_____

Signature and Date Stamps Are Not Acceptable.

INSTRUCTIONS FOR COMPLETING DME INFORMATION FORM FOR EXTERNAL INFUSION PUMPS (CMS-10125)

CERTIFICATION TYPE/DATE:	If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked "INITIAL," and also indicate the revision date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFICATION DIF, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date.
PATIENT INFORMATION:	Indicate the patient's name, permanent legal address, telephone number and his/her Medicare ID as it appears on his/her Medicare card and on the claim form.
SUPPLIER INFORMATION:	Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC) or applicable National Provider Identifier (NPI). If using the NPI Number, indicate this by using the qualifier XX followed by the 10-digit number. If using a legacy number, e.g. NSC number, use the qualifier 1C followed by the 10-digit number. (For example. 1Cxxxxxxxxxx)
PLACE OF SERVICE:	Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.
FACILITY NAME:	If the place of service is a facility, indicate the name and complete address of the facility.
SUPPLY ITEM/SERVICE PROCEDURE CODES:	List all HCPCS procedure codes for items ordered that require a DIF. Procedure codes that do not require certification should not be listed in this section of the DIF.
PATIENT DOB, HEIGHT, WEIGHT AND SEX:	Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if required.
PHYSICIAN NAME, ADDRESS:	Indicate the physician's name and complete mailing address.
PHYSICIAN INFORMATION:	Accurately indicate the treating physician's Unique Physician Identification Number (UPIN) or applicable National Provider Identifier (NPI). If using the NPI Number, indicate this by using the qualifier XX followed by the 10-digit number. If using UPIN number, use the qualifier 1G followed by the 6-digit number. (For example. 1Gxxxxxx)
PHYSICIAN'S TELEPHONE NO:	Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed.
QUESTION SECTION:	This section is used to gather clinical information about the item or service billed. Answer each question which applies to the items ordered, checking "Y" for yes, "N" for no, a number if this is offered as an answer option, or fill in the blank if other information is requested.
SUPPLIER ATTESTATION:	The supplier's signature certifies that the information on the form is an accurate representation of the situation(s) under which the item or service is billed.
SUPPLIER SIGNATURE AND DATE:	After completion, supplier must sign and date the DME Information Form, verifying the Attestation.

DO NOT SUBMIT CLAIMS TO THIS ADDRESS. Please see http://www.medicare.gov/ for information on claim filing.