ProHealth
Home Care

DEMO-100001

Detailed Written Order — Durable Medical Equipment

Patient: DELGADO, ANITA - MR#70001 Caregiver: Rosa Wilson (RN) Date: 11/15/2026

Patient Name: **Last: DELGADO First: ANITA**	MR Number: **70001**	DOB: **05/25/1930**
Location Name: **ProHealth Home Health Monterey**	Location Number: **01**	
Location Address: 2605 Center St Suite: City: Monterey State: CA Zip: 93940	Location Phone: (877) 381-5342 Location Fax: (877) 495-7516	
Physician Name: **ANDERSON, MEGHAN (MD) - 8290 Oak Ave, Detroit MI 48226**	Physician Address: 8290 Oak Ave City: Detroit State: MI Zip: 48226	
Physician Phone: **(313) 909-5748 Fax: (313) 779-6631**	Physician NPI: **1790935419**	
Order Date: **11/15/2026**	Requested Delivery: **11/17/2026**	Height / Weight: **67 in / 235 lbs**
Supplier: **Apex Medical Supply**	Medicare ID: **7UU9QA4AD24**	

Diagnoses

Primary Diagnosis	Date	ICD-10 Code
a. Cellulitis of left lower limb	11/15/2026	L03.116
Other Pertinent Diagnoses	**Date**	**ICD-10 Code**
b. Muscle weakness (generalized)	11/15/2026	M62.81
c. Dem in other dis classd elswhr, severe, with mood disturb	11/15/2026	F02.C3
d. Unspecified atrial fibrillation	11/15/2026	I48.91

Items Ordered

HCPCS: **E0570**	Nebulizer, with compressor	Qty: **1**	LON: **99 (lifetime)**
Medical necessity: **COPD requiring scheduled nebulized bronchodilators**			
HCPCS: **K0001**	Standard wheelchair	Qty: **1**	LON: **12 months**
Medical necessity: **Unable to ambulate safely within the home**			

I certify that the items ordered are medically necessary and reasonable for the treatment of the patient's condition. The patient has been evaluated in a face-to-face encounter within the last 6 months.

Physician's Signature & Date:	Physician NPI: **1790935419**

This form has been electronically signed by:

Rosa Wilson (RN) 11/15/2026 09:45:57 AM PST

Eugene Davis (Intake Coordinator) 11/16/2026 10:13:48 AM PST

Awaiting physician e-signature (Ordina)

Dr. Meghan Anderson, MD