# PRESCRIPTION

**PHYSICIAN'S INFORMATION**
**NAME:**
ADDRESS:
PHONE:
FAX:

**PATIENT INFORMATION**
**NAME:**
ADDRESS:
PHONE:

**DESCRIPTION OF REQUESTED DME:**

**DX:**

**LENGTH OF NEED:**

**# Months _____ OR Lifetime**
***(99 Months)***

**Notes:**

**BY SIGNING BELOW, I AUTHORIZE the use of this document as a legal prescription, and I certify that the above prescribed equipment is medically necessary and reasonable, and is not being purchased for convenience. I will maintain an original signed copy of this order in my medical records and make it available to Medicare, their authorized agents or other insurer, if required.**

**X** _____ _____

Physician's Signature Date