-- PRESCRIPTION --

DURABLE MEDICAL EQUIPMENT

PHYSICIAN INFORMATION
NAME:
ADDRESS:

PHONE:
FAX:
LICENSE:

PATIENT INFORMATION
NAME:
ADDRESS:

PHONE:
DOB:

DESCRIPTION OF REQUESTED DME:

DX:

LENGTH OF NEED:

 # Months ______ OR Lifetime *(99 Months)*

DATE OF FACE-TO-FACE EXAMINATION: ________________________

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 ____ Date: ____________________ NPI: _____________________