

**PHYSICIAN INFORMATION**

NAME:  
ADDRESS:  
  
PHONE:  
FAX:  
LICENSE:

**PATIENT INFORMATION**

NAME:  
ADDRESS:  
  
PHONE:  
DOB:

**DESCRIPTION OF REQUEST:**

**DX:**

**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: \_\_\_\_\_