

PRESCRIPTION FORM

This prescription is valid for one (1) year from date signed.



SECTION I					
PATIENT'S NAME			DATE OF BIRTH		
DIAGNOSIS					
LENGTH OF NEED					
<input type="checkbox"/> Indicate rental if applicable <input type="checkbox"/> Less than 6 months <input type="checkbox"/> Greater than 6 months <input type="checkbox"/> Number of months _____					
SECTION II					
ITEM	QUANTITY	SUPPLIES – FREQUENCY OF USE			
SECTION III					
PHYSICIAN'S PRINTED NAME		TELEPHONE NUMBER	FAX NUMBER	Physician NPI	
PHYSICIAN'S ADDRESS			CITY	STATE	ZIP CODE
I certify that I am the physician identified in Section III of this form and that the medical necessity information in Section I and II is true, accurate, and complete, to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact in those sections may subject me to civil or criminal liability.					
PHYSICIAN'S SIGNATURE and credentials				DATE SIGNED	