

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. (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTED).			
PHYSICIAN'S SIGNATURE			DATE SIGNED