

Patient's Name: _____

Fully describe item or service prescribed (please be specific):

Projected Monthly Frequency: _____

Diagnosis and Prognosis:

Estimated length of need: _____

Date Authorized: _____

Physician Name: _____

Physician Address: _____

Physician Phone: _____

Physician Unique Provider Number (UPIN): _____ (Do not Omit!)

Physician Signature: _____ Date: _____