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MEDICAL PHARMACY LTC
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CHAD WOJNAR R.PH., PRESIDENT
JACK LOVELAND R. PH., VICE PRESIDENT

Physician's Order Form for Urological Supplies

Date Ordered: ___/___/_____

Patient's Name: _____ DOB: _____/_____/_____

Patient's Address: _____

_____

Insurance ID #: _____ Height: ____'____" Weight: _____lbs

Equipment or Supplies Ordered:	**Quantity Per Month:**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Diagnosis/ICD-10 Code:_____ Length of Need: _____

Frequency of Use:_____

Physician Name:_____ NPI # _____

Physician's Address:_____

I, the undersigned, certify the above prescribed equipment and/or supplies are medically necessary as part of my treatment for this patient. In my opinion, the equipment and/or supplies prescribed are both reasonable and necessary for accepted standards of medical practice and treatment of this patient's condition. Neither the equipment and/or supplies are being prescribed as "convenience equipment".

Physician's Signature :_____Date ____/____/_____

LC