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CHAD WOJNAR R.PH., PRESIDENT
JACK LOVELAND R. PH., VICE PRESIDENT

Physician's Order Form

Date Ordered: _____ ☐ **Initial** ☐ **Renewal** **Date Of Exam:** _____

Patient Name: _____ **DOB:** _____

Patient Address: _____

Height: _____ **Weight:** _____

Insurance ID #: _____ **Length of Need:** _____

Physician:

Name:_____ **License #**_____ **NPI**_____

Physician's Address:_____

Phone: _____ **Fax:** _____

ICD-10 Code & Description

Equipment/Services

QTY	Procedure Code	Item Name/Narrative

Physician's Written Name: _____

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 Signed:** _____

LC