Stoll's Pharmacy, Inc.
185 Grove Street Waterbury, CT 06710
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DME Physician Order Form

Order Start Date: _____

Patient Name: _____ Date of Birth ____/____/____

Patient Street Address: _____ City, ST, Zip: _____

Dear Prescriber,

Stoll's Pharmacy, Inc. is in receipt of an order placed by you or your staff to provide services for your patient listed above. The information below is a written confirmation of this order. **Please fill in all pertinent information as well as modify any incorrect entries so that your patient receives their full medical insurance benefit.**

Description of Item(s) and Monthly Quantity Ordered:

1. Item: Quantity per month:
2. Item: Quantity per month:
3. Item: Quantity per month:
4. Item: Quantity per month:

Statement of Medical Necessity:

Diagnosis (**ICD-10-CM Code**):

Length of Need:

Please complete and sign below to indicate your acceptance of the above information and return the original form to us in the envelope provided. If you have any questions, please contact us at (203) 575-0199

Prescriber Name: _____ **Prescriber NPI #:** _____

Street Address: _____**City, ST, Zip** _____

Signature: _____ **Date Signed:** ____/____/___

SIGNATURE AND DATE STAMPS ARE NOT ACCEPTED BY INSURANCE COMPANIES

Supervising Physician Name (if applicable) _____

Signing Prescribers NPI # (If Different from above) _____