PHYSICIANS STATEMENT OF MEDICAL NECESSITY

Please be advised that the specific item(s) listed below are medically necessary to ensure effective treatment of the patient listed on this form. Any alteration forms this prescription may hider patient's recovery.

PATIENT NAME:____

PATIENT ADDRESS:____

CITY:______________________ STATE:____________ ZIP:__________

PATIENT TELEPHONE: _______________________________________

PATIENT D.O.B. ____

PATIENT ICD-10 DIAGNOSIS: __________________________________

____

ICD-10 CODE(s): ____

THIS PATIENT REQUIRES: ____________________________________

____

ESTIMATED LENGTH OF NEED

_____ 6 MONTH
_____ LONG TERMS
_____ OTHER

PHYSICIAN NAME: ____

PHYSICIAN ADDRESS: ____

____

PHYSICIAN NPI # ____

PHYSICIAN SIGNATURE ______________________________________