MEDI-RENTS & SALES INC.

Breast Pump

Physician Order/Prescription

Referred by: Name _____

Office _____

Phone # _____

800-540-7252

Fax completed form with Physician's Signature to 888-651-6709

Patient Information

Patient Name: _____ Date of Birth: _____ Gender M / F

Patient Phone #: _____ Alternate Contact: _____ Alternate Phone #: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Insurance & # _____ Social Security #: _____

Medicaid #: _____ Secondary Insurance: _____

Diagnosis Information

Primary Diagnosis/ICD-9 Code:

❍ Other (specify): _____

Length of Need:

❍ 1-99 months

❍ 99- lifetime

Start Date: ____ / ____ / ____ (MM / DD / YY)

Additional Supplies:

❍ Incontinence Supplies

❍ DME _____

❍ Other: _____

Physician Information

Physician's Name: _____ Phone #: _____ Fax #: _____

Address: _____ City: _____ State: _____ Zip: _____

UPIN #: _____ NPI #: _____ License #: _____ Exp Date: ____ / ____ / ____ (MM / DD / YY)

Physician's Signature _____ **Date** ____ / ____ / ____ (MM / DD / YY)

By my signature above, I confirm that the patient has the medical condition(s) listed and is being treated by me. All the information contained on this Physician's Order accurately reflects the patient's medical condition(s) and the treatment regimen that I have prescribed. The medical records for this patient substantiate the prescribed treatment plan. The patient/caregiver is able to use the prescribed product(s) listed above. My office has informed the patient that this order has been submitted to a DME supplier on behalf of the patient. For Medicare, Medicaid or other insurance requirements, I will maintain this signed original document in the patient's medical record file for post-payment review/audit purposes.

Medi-Rents & Sales, Inc. www.medirents.net

Approved By ACHC

Ref. No: G 594035656