DR.

ADDRESS:

Ph:
Fax:
NPI:

Medicare requires the following information to be kept in provider files:

Patient Name: _____ **Weight:** _____ **Height:** _____

DOB:_____ **AGE:** _____

Address:

START DATE: _____ **Refills:** _____

DIAGNOSIS: _____

_____

ICD – 9: _____

I, the undersigned, certify that the above prescribed supplies/equipment is medically necessary for this patient's well being.
In my opinion, the supplies are both reasonable and necessary to accepted standards of medical practice in treatment of this patient's condition and are not prescribed as convenience supplies.
By signing this form, I am confirming that the above information is accurate.

Physician Signature: _____ **Date:**