

Physician's Prescription

Please complete the information below and provide this form along with notes related to the relevant medical history, treatment and Insurance information.

Date of Prescription: _____

Patient Name: _____

DOA: _____

Patient Address: _____

Patient Tel: _____

Diagnosis: _____

Durable Medical Equipment Prescription

Shoulder arm-sling (simple)	
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Doctor's Notes: Patient is to wear prescribed Durable Medical Equipment:

_____x per week
10-20 Minutes Daily

_____x per week
2-3 Hours/day

To and From Work
3-6 Hours/day

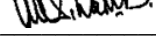
At Work
6-12 Hours/day

Additional Notes (if necessary):

Letter of Medical Necessity

As the referring provider, I certify that the above-prescribed order for the above checked Medical Equipment are medically necessary based on my diagnosis and as part of my overall treatment plan for my patient, who is identified by name at the top of this form. I have advised my patient that he/she had a right to choose the durable medical equipment (DME) supplier that provides the prescribed products pursuant to this order. By my signature, I am prescribing the item listed above.

Dr. Name: Anjani Sinha, MD

Dr. Signature: 

License Number: 147448

NPI: 1932233715