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: @txtproc_code_date

Patient Name: txtName|patientfullname DOA: txtDOA|DOA

Patient Address: txtAddress|fullAddress Patient Tel: txtPhone|Contact

Diagnosis: _____

Durable Medical Equipment Prescription

Shoulder arm-sling (simple)	

Doctor's Notes: Patient is to wear prescribed Durable Medical Equipment:

_____x per week	_____x per week	To and From Work	At Work
10-20 Minutes Daily	2-3 Hours/day	3-6 Hours/day	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