

Date: \_\_\_/\_\_\_/\_\_\_

**Patient Name:** \_\_\_\_\_

DOB: \_\_\_\_\_ Ph #: (    )    - \_\_\_\_\_

Diagnosis/ICD10: \_\_\_\_\_

Medical Necessity: *(i.e. immobilize to allow healing of fracture, increase comfort, etc.)*

**Rx**

Physician Declaration: I have reviewed the above-named patient's medical records and item(s) ordered. I certify these items are necessary for the patient's condition and authorize the selected items to be dispensed as ordered. I certify the noted diagnoses are accurate and are reflected in the patient's medical records.

Physician Signature: \_\_\_\_\_

Physician Name: \_\_\_\_\_ NPI: \_\_\_\_\_

Office Contact Name: \_\_\_\_\_

Phone #: \_\_\_\_\_

**Please attach physician's progress note, Patient demo's & additional studies & op-notes ( if applicable). We greatly appreciate your partnership.**

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