PRESCRIPTION FORM

(Enclosed Safety Bed)

Please send the completed prescription form to the patient's Durable Medical Equipment (DME) Supplier or return it to the patient to initiate their order directly with the supplier.

First Name:		**Last Name:**	
Address:			
City:		State:	Zip:
Phone:		Email:	
DOB:	Gender:	Height:	Weight:
Primary Insurance Provider:			
Secondary Insurance Provider:			
Member ID:		Secondary Member ID:	

BELOW THIS LINE TO BE COMPLETED BY A HEALTHCARE PROVIDER ONLY

ICD-10 Codes/Diagnoses (include any diagnoses related to sleep concerns):

Order Date: _____

Length of Need: (99 = lifetime) Duration of Need: _____ Months

☐ By checking here, I am referring the patient to PT/OT for an evaluation to review medical necessity for the requested enclosed safety bed.

Physician Printed Name:		NPI Number:
Physician Phone:	Fax:	Email:
Physician Address:		
City:	State:	Zip:
Preferred DME (if applicable):		
Physician Signature:		Date:

I certify that I am the treating physician. I certify that the medical necessity information contained herein is true, accurate, and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability. By signing this form, I attest that the information provided reflects the patient's current medical needs.