Reliable Medical Supply

DME Prescription Request Form

Patient Information:

Full Name:	DOB (mm-dd-yyyy):
Address:	Phone Number:
Insurance: ☐ Medicaid ☐ Medicare ☐ Private ☐ Self-Pay	Policy ID:

Refills Needed ☐	**Length Need:** ☐ 99 (lifetime) ☐ 12 Months ☐ Other			**Date: (mm-dd-yyyy)**
DX Code				

QTY	Detailed Item Description	HCPCS

Prescribing Physician Information:

I certify that the above equipment is medically necessary and prescribed for the patient listed above.

Physician Signature: _____ **Date:**

Physician Name: **NPI:**

Email: **Phone:**

Address: **Fax:**

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