Anodyne

PHONE: (952) 546-5334 ♦ www. AnodyneRehab.Com ♦ Info@AnodyneRehab.Com

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DURABLE MEDICAL EQUIPMENT PRESCRIPTION

Patient Name: ______________________________ Date of Birth: ____________

Address: __________________________ City: ________ State: ___ Zip: _______

ICD 10: _________, __________, ________, __________, __________

Length of Need: __________ (*# of months/99 = lifetime*)

Fully Describe Items Prescribed: *Include quantity, left, right, bilateral, knee, HCPCS etc.*

Equipment: ____________________________________

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ORDER DATE (required): ______________________

I have completed and/or reviewed all of the information contained in this statement and it is true and correct to the best of my knowledge. By my signature below, I authorize the use of this document by a licensed Durable Medical Equipment supplier as a detailed written order authorization and certification of medical need.

Physician Name: ______________________________ NPI: ________________

Physician Signature: ______________________________ Date: ____________

Phone: __________________________ Fax: __________________________

Please include supporting medical records and fax to:

Anodyne, Inc. 6024 Blue Circle Drive, Minnetonka, MN 55343 **FAX: (952) 546-2657**