

## DME Detailed Written Order

Patient Information	Clinical Information
Name:	ICD10 Diagnosis Code:
Insurance:	Diagnosis Code Description:
Date of Birth:	Length of Need:

Item:		
Qty:	Days Supply:	# of Refills:
Directions:		

Item:		
Qty:	Days Supply:	# of Refills:
Directions:		

Item:		
Qty:	Days Supply:	# of Refills:
Directions:		

### Medical Documentation Required and Must Pertain to the Diagnosis and Items Requested

I have reviewed my patients' records and the items requested above. My signature below certifies that I have physically examined the patient within the last 6 months and have established that this patient has a chronic pathological condition. I authorize the item(s) described above as medically necessary for the patient. A copy of this order will be maintained within the recipient's medical record.

***My signature below further certifies that I am the ordering physician, physician assistant or nurse practitioner identified on this form. I also certify that the medical necessity information is true, accurate and complete to the best of my knowledge.***

Signature of Physician, Physician Assistant, Nurse Practitioner		Printed Name of Physician, Physician Assistant, Nurse Practitioner	
NPI#	Signature Date:	Phone#:	Fax#:

Once completed fax to the Community Pharmacy corporate office at 207-622-0952. Insurance and plan limits will be verified, and the order processed for shipment the same day. All orders are delivered to the customers home within 1-2 business days.

All questions regarding coverage and benefits can be directed by calling 207-622-3264, select option 3 for ordering. Our hours of business are 8 a.m. to 4:30 p.m. Monday thru Friday.