Pink Lift LLC Post Mastectomy DME/Medical Supplies Physician Order Form

Section A: Requested Durable Medical Equipment and Supplies

This section was completed by (check one): □ Requesting Physician □ Supplier

Patient Name:	**Patient Address:**	
Patients Phone:		Date of birth: / /

Supplier Information

Name: Pink Lift LLC Phone: (813 361-9076) Fax: (813) 441-8976

Address: 720 Islebay Drive, Apollo Beach, FL 33572

EIN: 83-1803784		L Code : L8000, L8001, L8002, L8015, L8020, L8030
DCN Number: 19288002000000		

I certify that the services being supplied under this order are consistent with the physician's determination of medical necessity and prescription.

DME/medical supplies provider representative signature:	Date: / /

DME/medical supplies provider representative name (Typed or Printed):

DME Order Physicians Inforrmation

Name:	Telephone:	Fax number:

Item Number	HCPCS Code	Description of DME/medical supplies	Quantity
1			
2			
3			
4			

1. If "Yes," additional documentation must be provided to support determination of medical necessity.

Section B: Diagnosis and Medical Need Information

This is a prescription for DME/supplies and must be filled out by the prescribing physician.

Item Number[2] (From Section A)	Diagnosis	Brief Diagnosis Descriptor	Notes to Supplier

2. Patients Primary Insurance Company: ID: Group Number :

Secondary Insurance:

Prescribers/Physicans Name & Address:

Refills Allowed:	Date last seen by physician: / /

Signature of prescribing physician: Date: / /

Electronic Signature is acceptable

Prescribing physician's license number:

Prescribing physician's/NPI Phone NumberI:	Prescribing physician's/NPIFax Number: