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PAPERWORK FOR MEDICARE

Patient Name: _____ Date of Birth: _____
Patient Address: _____
Phone Number: _____ HICN (Medicare #) _____
Sex: _____ Height: _____ Weight: _____

Items being ordered by patient:

HCPCS CODES: _____

- 1): _____
- 2): _____
- 3): _____
- 4): _____
- 5): _____
- 6): _____
- 7): _____

Estimate length of need (# of months): _____ (99 = lifetime)

Diagnosis Codes: _____

Physician Name: _____ Physicians NPI #: _____

Address: _____

Phone Number: _____ Physician Fax Number: _____

**** PHYSICIAN SIGNATURE: _____ DATE: _____**