

HEALTH AND RECOVERY SERVICES ADMINISTRATION (HRSA) PRESCRIPTION FORM



This prescription is valid for one (1) year from date signed.

SECTION I					
PATIENT'S NAME			DATE OF BIRTH		
DIAGNOSIS					
LENGTH OF NEED					
<input type="checkbox"/> Indicate rental if applicable <input type="checkbox"/> Less than 6 months <input type="checkbox"/> Greater than 6 months <input type="checkbox"/> Number of months _____					
SECTION II					
ITEM	QUANTITY	SUPPLIES – FREQUENCY OF USE			
SECTION III					
PHYSICIAN'S PRINTED NAME		TELEPHONE NUMBER	FAX NUMBER	REFERRING PHYSICIAN'S NUMBER	
PHYSICIAN'S ADDRESS			CITY	STATE	ZIP CODE
I certify that I am the physician identified in Section III of this form and that the medical necessity information in Section I and II is true, accurate, and complete, to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact in those sections may subject me to civil or criminal liability. (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTED).					
PHYSICIAN'S SIGNATURE				DATE SIGNED	