JACKSON PHARMACY
668 S Jackson Rd
Edinburg, TX 78539
Phone: (956) 292-0404 • Fax: (956) 292-

Physician's Order

Please Complete the Following Information Legibly: **Date:** _____

Patient Name: _____ **Date of Birth:** _____

Street Address: _____

City, State, Zip: _____ **Phone Number:** _____

Patient ID Number (Medicare Number): _____

Patient Secondary Insurance ID Number (Medicaid): _____

Patient Height: _____ **Weight:** _____ **Sex (PLEASE CIRCLE): MALE FEMALE**

THIS SECTION MUST BE COMPLETED BY THE PRESCRIBING PHYSICIAN

Diagnosis:

_____

Prognosis: ☐ **Poor** ☐ **Fair** ☐ **Good**

HCPCS	DME Equipment	Quantity	Duration of Need

I, the undersigned, certify that the above-prescribed equipment/medication is MEDICALLY NECESSARY for this patient's well being. In my opinion, the equipment is both reasonable and necessary in reference to accepted standards of medical practice in treatment of this patient's condition and is not prescribed as convenience equipment.

Prescribing Physician (Print Physician's Name): _____

Physician's UPIN: _____ **NPI:** _____

Address: _____

City, State, Zip: _____

Physician's Phone Number: _____

Physician's Signature: _____ **Date:** _____