Rx Standard Written Order (SWO) **All fields are required for insurance approval.**

SunMED Medical Solutions

Start your order online today at SunMEDChoice.com
or by submitting this form to SunMED by fax or email
inbox@sunmedmedical.com
FAX 800-715-5422 | Phone 855-477-4507

Patient Name: _____ **Date of Birth:** _____
(Last) (First) (M)

Patient Cell # _____ **Patient Home #** _____

Email _____

Patient Address: _____

Upper Extremity	**Lower Extremity**
☐ Left ☐ Right ☐ Bilateral	☐ Left ☐ Right ☐ Bilateral
☐ Sleeve ☐ Glove ☐ Gauntlet	☐ Knee High ☐ Thigh High ☐ Chaps
☐ Other_____	☐ Pantyhose ☐ Other_____
Compression	Compression
☐ 15-20 ☐ 20-30 ☐ 30-40 ☐ 40-50	☐ 20-30 ☐ 30-40 ☐ 40-50
Quantity: ☐ 1 ☐ 2 ☐ 3	Quantity: ☐ 1 ☐ 2 ☐ 3

Diagnosis: ☐ I89.0 ☐ Q82.0 ☐ I97.2 ☐ I97.89
Length of Need: __99_____
 # Refills (per 12 months): _____

MD Name (Printed): _____ **NPI#:**_____

Address: _____

Phone: _____ **Fax:** _____

Physician Signature Required: _____ **Date:** _____

Notes: _____

_____

_____

_____