PHYSICIAN'S WRITTEN ORDER

Fax or email this form to SunMed Medical
FAX # 800-715-5422 | **Phone**# 855-304-2939
Email : nalumed@sunmedmedical.com
www.SunMEDChoice.com

Rx This form is a Prescription and Statement of Medical Necessity. All fields are required for insurance approval.

PATIENT INFORMATION

Patient First Name: Please Print		Patient Last Name: Please Print
Date of Birth:	Mobile Phone:	Alternate Phone:
Address:		Suite / Unit:
City:	State:	ZIP Code:
E-Mail:		Gender:
Primary Insurance Name:		Primary Insurance ID:
Secondary Insurance Name:		Secondary Insurance ID:

Check one (1) as applicable:

HCPCs *Product*

☐ L8683 **Therapy Disc,** Quantity _____

☐ A4438 **Adhesive Clip**
- ☐ **Strong Hydrocolloid** Quantity _____
- ☐ **Light Hydrocolloid** Quantity _____
- ☐ **Sensitive Skin** Quantity _____
- ☐ **Silicone** Quantity _____

PRESCRIBER INFORMATION

Prescriber First Name: Please Print		Prescriber Last Name: Please Print
Office Contact/Transmitting Personnel:		NPI #:
Address:		Suite / Unit:
City:	State:	ZIP Code:
Phone Number:	Fax Number:	

Provide Diagnosis (Include ICD-10 code & description): _____

_____

Length of need: _____months *(99 means lifetime)*

IMPORTANT: Patient chart notes must be submitted that show medical necessity for the devices ordered to understand why their current device is not meeting their medical need.

I certify that I am the physician identified on this form. I have reviewed this Physician's Written Order. Any statement on my letterhead attached hereto has also been reviewed and signed by me. I certify that this patient and/or caregiver is capable and will be trained on the proper use of the products prescribed on this Written Order. The patient's record contains supporting documentation that substantiates the utilization and medical necessity of the product listed, and the physician notes and other supporting documentation will be provided upon request. I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability. A copy of this order will be retained as part of the patient's medical record.

Physician Signature Required: _____ Date: _____

Stamps are not acceptable