




# PHYSICIAN PRESCRIPTION FORM

Patient Name: _____		SSN: _____ - _____ - _____	
Address: _____			
City: _____		State: _____	Zip: _____
Patient E-mail: _____			
Phone ( ) _____ - _____		DOB ____/____/____	Gender <input type="checkbox"/> M <input type="checkbox"/> F
Other contact _____		Other phone ( ) _____ - _____	

Managed Care:  HMO  PPO  POS Physician's Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_ - \_\_\_\_\_

<b>Primary Ins. Name</b> _____	<b>Secondary Ins. Name</b> _____
Address _____	Address _____
City _____ Zip _____	City _____ Zip _____
Phone ( ) _____ - _____	Phone ( ) _____ - _____
Subscriber: _____	Subscriber: _____
Date of birth ____/____/____	Date of birth ____/____/____
SSN # _____ - _____ - _____	SSN # _____ - _____ - _____
Policy # _____	Policy # _____
Group ID # _____	Group ID # _____
Employer: _____	Employer: _____

**Release of Information:** I authorize the release of any medical or other information necessary to process claims for services by **QAS** (provider) and for supply of products by **QAS** (provider). I also authorize the release of any medical or other information to CMS, its agents, contractors, my insurance company or **QAS** (provider) necessary to determine the benefits payable. **Assignment of Benefits:** I request that Medicare and/or any other insurance plans under which I am covered make payment to the provider of authorized benefits on my behalf for services and supplies furnished to me for which they bill. I (the below signed) agree to accept the charge determination of the insurance carrier as the full charge. I am responsible for the deductible, co-insurance and non-covered services. **Privacy Policy:** I have read and understand the privacy policy.

 Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

<b>Prescribing Physician Information</b>	<b>Follow-up Physician Information</b>
Name _____	Name _____
Address _____	Address _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____
Phone ( ) _____ - _____ Fax ( ) _____ - _____	Phone ( ) _____ - _____ Fax ( ) _____ - _____
License # _____ UPIN# _____	License # _____ UPIN# _____

Diagnosis Code: \_\_\_\_\_ Start date of Warfarin therapy \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of surgery \_\_\_\_/\_\_\_\_/\_\_\_\_.  
 Maintain INR range between a low of \_\_\_\_\_ and a high of \_\_\_\_\_ with a target of \_\_\_\_\_  
 (Achieved through the PPM Monitoring Program as documented in the following PPM physician orders.)

Items Prescribed	Product Number	Qty.	Refills	Prescribed Frequency
ProTime Microcoagulation System	L11-01-01C	1	N/A	<input type="checkbox"/> 1 test per week <input type="checkbox"/> Other ____ test(s) per _____
Cuvettes (4 pack)	L21-01-0004		<input type="checkbox"/> Lifetime <input type="checkbox"/> Other	
Cuvettes ( box of 25)	L21-01-0025		<input type="checkbox"/> Lifetime <input type="checkbox"/> Other	

I will insure the patient receives appropriate training on the monitoring device. I, the undersigned, certify that the above prescribed product supplies and medically necessary for this patient's well being. In my opinion, these products are reasonable and necessary in reference to accepted standards of medical practice in the treatment of this patient's condition and are not prescribed as convenience items.

**Physician signature** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
 \_\_\_\_\_  
 (Signature must be hand written. No stamps allowed.)  
**Phone ( )** \_\_\_\_\_ - \_\_\_\_\_ **E-mail** \_\_\_\_\_

**Please fax completed and signed order immediately to: 407-563-2861**

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