NYS MEDICAL ASSISTANCE - TITLE XIX PROGRAM

ORDER/PRIOR APPROVAL REQUEST

Г	00000 0400	RX DRUGS / OTC	DME / SUPPLIES	NURSING	EYE CARE	PHYSICIAN
	ORDER DATE PRESCRIBING PROVIDER NUMBER PROFCODE	X	X	X	X	X
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	PRESCRIBED BY (NAME)	ADDRESS				
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1	ADDRESS	PRESCRIBER TELEPHONE NUMBER	DATE OF BIRT	TH CITY		STATE ZIP CODE
	CITY STATE ZIP CODE	PRESCRIBER SIGNATURE	M, M, D, D,	M M D D C C Y Y		SEX M F
1	ORDER DESCRIPTION/MEDICAL JUSTIFICATION					
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