

ORDER DATE M M D D C C Y Y		PRESCRIBING PROVIDER NUMBER	PROF CODE	RX DRUGS / OTC <input checked="" type="checkbox"/>	DME / SUPPLIES <input checked="" type="checkbox"/>	NURSING <input checked="" type="checkbox"/>	EYE CARE <input checked="" type="checkbox"/>	PHYSICIAN <input checked="" type="checkbox"/>	
PRESCRIBED BY (NAME)				PRIMARY DIAGNOSIS	SECONDARY DIAGNOSIS	CLIENT ID	CLIENT NAME		
ADDRESS				PRESCRIBER TELEPHONE NUMBER		DATE OF BIRTH	CITY	STATE ZIP CODE	
CITY	STATE	ZIP CODE		PRESCRIBER SIGNATURE		CLIENT TELEPHONE NUMBER		SEX M F	
ORDER DESCRIPTION/MEDICAL JUSTIFICATION									
SERVICING PROVIDER NUMBER		SERVICING PROVIDER NAME			TELEPHONE NUMBER		LOC CODE		
ADDRESS									
DRUG CODE (NDC)	PROCEDURE/ITEM CODE	MOD	RENTAL?	DESCRIPTION	QUANTITY REQUESTED	TIMES REQUESTED	TOTAL AMOUNT REQUESTED		
1			Y N						
2			Y N						
3			Y N						
4			Y N						
5			Y N						
6			Y N						
7			Y N						
DO NOT STAPLE IN BARCODE AREA				PA REVIEW OFFICE CODE					↑ ← ALIGN TOP AND LEFT EDGES OF STICKER ATTACHMENT NUMBER
									

Sample - Not For Submission