Merion
Medical Supply

1100 First Avenue, Suite A
King of Prussia, PA 19406
Phone: 866.625.3615
Fax: 484.636.0225

Durable Medical Equipment Prescription

Effective Date of Prescription: .....

Section 1: Members Information

Name: ..... Insurance: .....

Address: ..... ID #: .....

..... Date of Birth: .....

Phone: ..... Alternative Phone: .....

Diagnosis: .....

ICD-10-CM Code: ..... / ..... / ..... / .....

Section 2: Prescribing Providers Information

Provider Name: ..... Phone: .....

Address: ..... Fax: .....

..... NPI: .....

Section 3: For Durable Medical Equipment

ITEMS REQUESTED	HCPCS CODE	MODIFIERS
1.	.....	.....
2.	.....	.....
3.	.....	.....
4.	.....	.....

Section 4

Medical justification for requested item(s) along with any settings, therapeutic outcome, and previous treatment plans (if applicable). Please attach any pertinent information. (Visit notes, lab tests, radiology reports, etc.)

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Section 5: Providing Providers Attestation, Signature and Data

I certify that I am the prescribing provider identified in section 2 of this form. Any statement on my letterhead has been reviewed and signed by me. I certify that the medical necessity information (per 130 CMR 450.204) on this form is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

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PRESCRIBING PROVIDERS SIGNATURE DATE