



a CHC Solutions Company

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PRIVATE PAY ORDER FORM

**\*\*Please attach face sheet w/ patient demographics\*\***

PATIENT INFORMATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender:  Male  Female  
Language Pref.:  English  Spanish  Other: \_\_\_\_\_ Does this patient have insurance?  Yes  No

PRODUCT SELECTION

Wound Dressing

Qty

Cost

Total:

REFERRAL INFORMATION

Practice Name: \_\_\_\_\_ Fax: \_\_\_\_\_  
Office Address: \_\_\_\_\_ Email: \_\_\_\_\_  
Phone: \_\_\_\_\_ Preferred Method of Contact?  Phone  Fax  Email

Physician Name: \_\_\_\_\_ NPI#: \_\_\_\_\_ Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Ext. \_\_\_\_\_  
Physician Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

*I certify that the above products are medically necessary and that the information provided is accurate to the best of my knowledge. By signing below, I acknowledge that I have obtained the patient's authorization to release the above information and other medical information that may be disclosed. I certify that my decision to prescribe this recommended product was solely based on my determination of medical necessity set forth herein. This document may serve as a confirmation of a verbal order and is also recorded in the patient's record.*

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_