



ADVOCATE

Medical Services, Inc.

Onward together.™

FAX 877.426.7329

877.968.7267 En Español 877.968.7260

PATIENT PRESCRIPTION REQUEST FORM

PATIENT INFORMATION

Form fields for Patient Information: LAST NAME, FIRST NAME, DOB, STREET, CITY, STATE, ZIP, PHONE, SS#, LENGTH OF NEED (MONTHS), PRIMARY INSURANCE CARRIER, INSURANCE. I.D. #

Rx - SUPPLIES REQUIRED

MEDICAL JUSTIFICATION

Table with columns: QTY/MO, SIZE, DESCRIPTION, MEDICARE. Rows include UROLOGY SUPPLIES, BOWEL CARE SUPPLIES, INCONTINENCE SUPPLIES, OSTOMY SUPPLIES, WOUND CARE SUPPLIES, and SKIN CARE.

Form fields for Medical Justification: RX START DATE, PATIENT NOTES

DIAGNOSIS - PLEASE CHECK ALL THAT APPLY

Form for Diagnosis with columns: Urology / Incontinence, Ostomy, Wound Care. Includes checkboxes for various medical conditions.

Form field for SUPPLY NOTES

PHYSICIAN'S INFORMATION

Form fields for Physician's Information: Physician's Name, Address, City/State, Zip Code, License #, UPIN #, Telephone, Physician's Signature, Date

Please complete and fax to: 877.426.7329 PLEASE NOTE: By law, patients cannot receive supplies until this signed prescription is received. Thank you!