	Detailed Written Physician Order
Patients Name:	SSN#
Address:	Phone #:
	DOB:
Initial Date of Order: _____/_____/_____ Length of Time Needed:	
Diagnosis (ICD-9) Code: (1) (2) (3)	
Prognosis: Good Fair Poor Height: Weight:	
Detailed Description of Equipment and/or Supplies: (List HCPCS code for each item)	
Please document medical necessity for this order:	
Provider: Womens Health Boutique 510 E. Loop 281, Suite B Longview, TX 75605-5076 903-758-9904 Fax 903-236-9786 NSC # 752610537	Physician: Phone: Fax #: NPI #:
Physician's Signature:	
Date:	