



**SSM**Health.  
*at Home*

**Generic RX**

**FAX COVER**

To: \_\_\_\_\_ From: \_\_\_\_\_  
 Fax: \_\_\_\_\_ Pages: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Date: \_\_\_\_\_

Remarks:  Urgent  For Your Review  Please Comment  Please Reply

**Message: Please complete all the information below for your order. This Rx (completely filled out) will serve as a detailed order.**

**Standard Written Order for Durable Medical Equipment & Supplies**

Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient Address: \_\_\_\_\_

Length of need: 12 Quantity: \_\_\_\_\_ Frequency or Direction of use: \_\_\_\_\_

Item Description: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Provider Name (please print): \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Provider Address: \_\_\_\_\_

NPI#: \_\_\_\_\_

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