Washington State Health Care Authority

# PRESCRIPTION FORM

**This prescription is valid for one (1) year from date signed.**

| SECTION I | |
|---|---|
| PATIENT'S NAME | DATE OF BIRTH |
| DIAGNOSIS | |
| LENGTH OF NEED<br>☐ Indicate rental if applicable ☐ Less than 6 months ☐ Greater than 6 months ☐ Number of months _____ | |

| SECTION II | | |
|---|---|---|
| ITEM | QUANTITY | SUPPLIES – FREQUENCY OF USE |
| **PATIENT LIFT W/ SLING** | **1** | **DAILY** |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

| SECTION III | | | |
|---|---|---|---|
| PHYSICIAN'S PRINTED NAME | TELEPHONE NUMBER | FAX NUMBER | Physician NPI |
| PHYSICIAN'S ADDRESS | | CITY | STATE ZIP CODE |
| I certify that I am the physician identified in Section III of this form and that the medical necessity information in Section I and II is true, accurate, and complete, to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact in those sections may subject me to civil or criminal liability. | | | |
| PHYSICIAN'S SIGNATURE and credentials | | | DATE SIGNED |