AMBULATORY INFUSION CARE, INC.

CLINICAL HOSPITAL PHARMACY MANAGEMENT

www.AmbulatoryInfusionCare.com

Date:_______
Dear Dr. ______________________

Your patient________________________________,DOB_________is requesting our pharmacy services for his/her medical supplies. In order to bill the applicable insurance plan, we ask that you fill out the information below and fax this sheet to 989-773-5233.

Physicians Prescription

Patient's name:________________________
Address____ Phone: ___________________

TO BE COMPLETED BY PHYSIC£AN

Diagnosis: (Please Check One)

_________ Ileostomy (V44.2, V55.2) __________Colostomy (V44.3, V55.3)

_________Other Artificial Opening of the Urinary Tract (V44.6, V55.6)

_________(Other)____

Length of Order:.____________________(12 months if not otherwise specified)

Rx

Skin Barrier____

Pouch ____

Ostomy Belt.____

Adhesive Remover
Wipes (A4365)____

Ostomy Supplies
Misc. (A4421)____

Other____

Physician'sSignature:_________________________________Date:____________________

UPIN#:____