

Medical Resources

Medical Equipment, Supplies and Furnishings

Medical Authorization Form

(Required for Purchase of a Medical Device by a Non-Physician)

PATIENT'S INFORMATION:

Patient's Name: _____

Patient's Address: _____

City _____ State _____ Zip _____

PHYSICIAN'S INFORMATION:

Authorizing Physician's Name: _____

Physician's Address: _____

City _____ State _____ Zip _____

Physician's Phone Number: _____

UPIN Number _____

Physician's Signature

Date

Please Return via FAX or EMAIL to Medical Resources:

Email: inquiries@medicalresources.com

Fax: 740-201-3309