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 ☐ Indicate rental if applicable ☐ Less than 6 months ☐ Greater than 6 months ☐ Number of months _____	

SECTION II		
ITEM	QUANTITY	SUPPLIES – FREQUENCY OF USE

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