

Referral R_x Form

Date: _____

Patient Information (Please Print)

Member Name: _____

Shipping Address: _____

Phone Number: _____ Date of Birth: _____

Medicare ID #: _____ Medicaid / CHIP #: _____

Individual & Family (Exchange) #: _____

Patient must be 18 years of age or pregnant.

Physician's Information

Physician's Name: _____

Physician's NPI #: _____

Office Contact Name: _____

Physician's Phone Number: _____ Physician's Fax Number: _____

R_x Date: _____ Physician's Signature: _____

Diagnosis Code: _____

Product Needed

Digital Blood Pressure Monitor



Return to:

Home Delivery Incontinent Supplies, Inc.

Phone: 1-855-892-2104 | Email: HPPSupport@hdis.com | Fax: 833-396-4663

This fax contains confidential information intended for the person(s) to whom it is addressed. If you should receive this in error please contact us immediately by return fax or at the above phone number. Unauthorized use of this information may be in violation of criminal statutes or HIPAA Regulations. Under no circumstances shall this material be retained, transmitted, or copied by anyone other than the addressee(s).

Contact ID: 830792