Stoll's Pharmacy, Inc.
185 Grove Street Waterbury, CT 06710
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www.StollsPharmacy.com ◆ Email: Info@StollsPharmacy.com

Stockings

Patient Name: _____ Date of Birth ____/____/____

Patient Street Address: _____ City, ST, Zip: _____

Dear Prescriber,

Stoll's Pharmacy, Inc. is in receipt of an order placed by you or your staff to provide services for your patient listed above. The information below is a written confirmation of this order. **Please fill in all pertinent information as well as modify any incorrect entries so that your patient receives their full medical insurance benefit.**

Equipment ordered:
Surgical Stockings
Below Knee _____
Thigh length _____
Panty hose _____

Qty#_____ (Pairs) Refills_____ Order Start Date: _____
Compression Required
20-30mm_____
30-40mm_____
40-50mm_____
Anti- Embolism

Diagnosis (**ICD-10-CM Code**) _____
Length of need _____
Location of Wound_____
Was wound Debrided? YES_____NO_____
Date of Debridement_____ Type of Debridement_____

Severity of condition ____Extreme ____Acute ____Grave ____Infected ____Other

Prognosis ____Good ____Guarded ____Poor

Please complete and sign below to indicate your acceptance of the above information and return the original form to us in the envelope provided. If you have any questions, please contact us at (203) 575-0199

I, the undersigned, certify that the above prescribed equipment and/or supplies are medically necessary as part of my treatment for this patient. In my opinion, the equipment and/or supplies prescribed are both reasonable and necessary for accepted standards of medical practice and treatment of this patient's condition and are not being prescribed as "convenience" equipment.

Doctor Name: _____ **Prescriber NPI #:** _____

Street Address: _____**City, ST, Zip** _____

Signature: _____ **Date Signed:** _____/_____/_____

Signing Prescribers NPI # (If Different from above) _____

SIGNATURE AND DATE STAMPS ARE NOT ACCEPTED BY INSURANCE COMPANIES