

# Durable Medical Equipment Prescription Verification

**Date:** [Insert Date]

**Patient Name:** [Insert Patient Name]

**Patient Address:** [Insert Patient Address]

**Patient Phone:** [Insert Patient Phone Number]

**Provider Name:** [Insert Provider Name]

**Provider NPI:** [Insert Provider NPI]

**Provider Contact Information:** [Insert Provider Contact Info]

## Prescription Details

**Item Requested:** [Insert DME Item Name]

**Quantity:** [Insert Quantity]

**Diagnosis:** [Insert Diagnosis]

**Start Date:** [Insert Start Date]

## Verification Checklist

- Patient's medical necessity verified.
- Prescription is signed and dated by the physician.
- Appropriate DME codes provided.

Thank you for your attention to this matter. Please contact our office with any questions or additional information needed regarding this prescription verification.

**Sincerely,**

[Your Name]

[Your Title]

[Your Company]

[Your Contact Information]