



**PHONE: 1.844.317.9620 FAX: 1.844.317.9378**  
**EMAIL: orders@chcsolutions.com**

**PRIVATE PAY ORDER FORM**

*\*\*Please attach face sheet w/ patient demographics\*\**

**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender:  Male  Female  
 Language Pref.:  English  Spanish  Other: \_\_\_\_\_ Does this patient have insurance?  Yes  No

**PRODUCT SELECTION**

Wound Dressing	Qty	Cost
Total:		

**REFERRAL INFORMATION**

Practice Name: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Office Address: \_\_\_\_\_ Email: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Preferred Method of Contact?  Phone  Fax  Email

Physician Name: \_\_\_\_\_ NPI#: \_\_\_\_\_ Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Ext. \_\_\_\_\_  
 Physician Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

*I certify that the above products are medically necessary and that the information provided is accurate to the best of my knowledge. By signing below, I acknowledge that I have obtained the patient's authorization to release the above information and other medical information that may be disclosed. I certify that my decision to prescribe this recommended product was solely based on my determination of medical necessity set forth herein. This document may serve as a confirmation of a verbal order and is also recorded in the patient's record.*

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_