Materna Medical

Milli Rx Form

Fax: (855) 237-9113 | Toll Free: (855) 237-9112

NPI 1598013864

Prescriber Name ______________________________

PATIENT

PLEASE INCLUDE FACE SHEET & INSURANCE CARDS

Name ______________________________ **DOB** ____________ **Phone** ____________________

Address ______________________________ **City, State** ____________________ **Zip** __________

MEDICAL ASSESSMENT

Height & Weight: ______________________ **Allergies:** ______________________________

ICD-10 code & description ☐ ______________________________ ☐ ______________________________

PRESCRIPTION

☐ **Milli Vaginal Dilator** **Quantity** ________ ☐ DAW

☐ **SIG** 5 to 20 minutes, 3 to 5 times per week.

☐ **SIG** ____

PROVIDER

PLEASE INCLUDE ALL CLINICAL NOTES

Office Contact ______________________________ **Phone** ________________ **Fax** ________________

______________________________ (____________________) ____________________

Prescriber Signature *NPI or DEA* *Date*

***By signing this form and utizing our services, you authorize Carepoint and its employees to serve as your designated agent for handling prior authorizations and other medical and prescription insurance forms and communications*

FORM_100.0516

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