**EXAMPLE DETAILED PRODUCT DESCRIPTION**

COMPANY

ADDRESS

PHONE/FAX

Beneficiary Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HICN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HCPCS CODE DESCRIPTION OF THE EQUIPMENT QUANTITY**

K0823 Drive Trident 2850-18 1

E2361 NF‐22 Battery 2

Physician/Ordering Practitioner’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician/Ordering Practitioner’s Name (Print clearly) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Physician/Ordering Practitioner’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician/Ordering Practitioner’s NPI \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_