Washington State Health Care Authority

Prescription form (standard written order)

This prescription is valid for one (1) year from the date signed.

1 General information

Client's full name

Date of birth

Client ProviderOne ID

Diagnosis (please include ICD 10 and description)

2 Request details

Please enter the requested medical supply, equipment, and/or service, the quantity needed, and frequency of use in the box below. Item description, HCPCS code or narrative is acceptable. (Example: Item, 1, 2x per day)

Item	Qty	Frequency
Item	Qty	Frequency
Item	Qty	Frequency
Item	Qty	Frequency
Item	Qty	Frequency
Item	Qty	Frequency

3 Provider signature

Prescribing provider's printed name with credentials

Telephone number

Fax number

Billing Provider's NPI

I attest that I am the provider identified in Section III of this form and that the medical necessity information in Section I and II is true, accurate, and complete, to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact in those sections may subject me to civil or criminal liability.

Prescribing provider signature

Date