General Fax Order Form

Attention: Jen Daetwyler x3821 **Ref. #:**

Please complete all fields, as inaccurate or incomplete information may delay this order.

edgepark® Medical Supplies Since 1928

What you need, when you need it.®

p 1-800-321-0591 f 330-963-6172
w www.edgepark.com

facility

Health Care Professional: _____

Facility: _____

Phone #: _____ Fax #: _____

patient

First: _____ Last_____ MI _____ Patient DOB: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone #: _____ E-mail Address: (optional) _____

insurance

Primary: _____

Contract/Policy #: _____

Group #: _____

Phone #: _____

Secondary: _____

Contract/Policy #: _____

Group #: _____

Phone #: _____

doctor

Physician Name: _____

Street Address: _____

City/State/ZIP: _____

Phone #: _____

Fax #: _____

diagnosis

*Please Indicate Diagnosis

_____

_____

_____

_____

*By faxing this form you are acknowledging that the patient is aware that an Edgepark Representative may be contacting them for any additional information needed to process this order.

ITEM #	PRODUCT DESCRIPTION	QTY

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NOTES

Most orders will ship within 24 – 48 hours of receipt, depending on insurance authorization and patient consent.

Comparable-quality products may be used to maximize patient benefits unless otherwise indicated.

* Is the patient under any type of care in the home or any other facility (HHC/SNF/hospital)? Yes☐ No☐

* If "yes":

Facility Name: _____

Facility Phone #: _____

Start of Care Date: _____

Discharge Date: _____

My signature below indicates that I am authorized by Dr. _____ to order the supplies listed. Dr. is aware he/she will be receiving Detailed Written orders to complete on behalf of this patient.

Signature/title: _____ Date: ____/____/____ Printed Name: _____