Milli Rx Form

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

NPI 1598013864

Prescriber Name _____

PATIENT

Name _____ DOB _____ Phone _____

Address _____ City, State _____ Zip _____

MEDICAL ASSESSMENT (Optional)

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 _____

Discount Code _____

PROVIDER

Office Contact _____ Phone _____ Fax _____

_____ (_____) _____

Prescriber Signature *NPI or DEA* *Date*

**By signing this form and utiizing 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*